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Legislation Directly Affecting You... see page 18

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IF MORE MEN CRIED



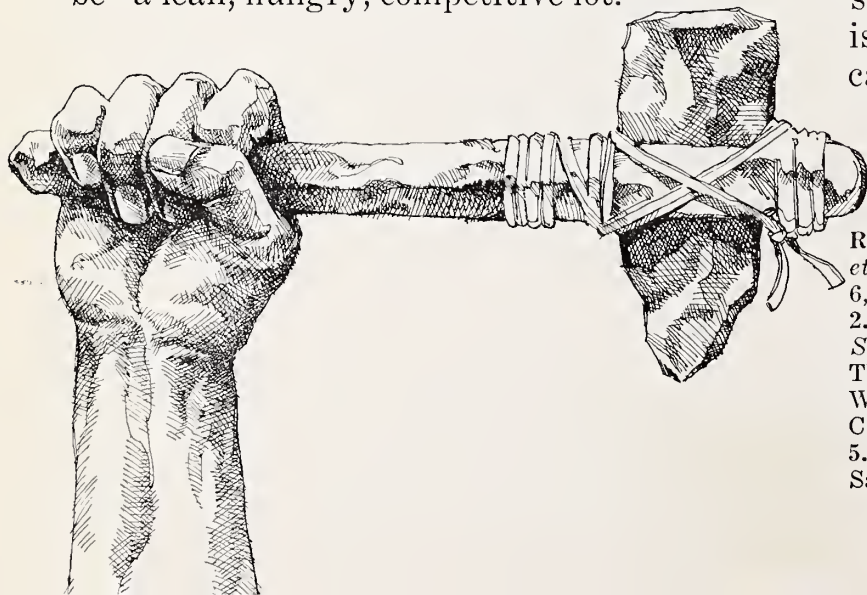
At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."²

Hypersecretion—an atavistic response.

Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."³



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total



their genes and what they are taught. Schottstaebgen observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.⁴ Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.

Take away stress, you can take away symptoms

There is no question that stress plays a role in the etiology of duodenal ulcers. Alvarez⁵ observes that many a man with a duodenal ulcer loses his symptoms the day he shuts out the office and starts out on a vacation. The problem is, the type of man likely to have a duodenal ulcer is the type least likely to take long vacations or take it easy at work.

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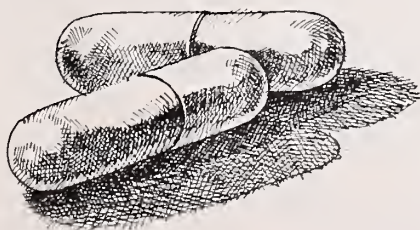
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Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, over-sedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Contents

Scientific Articles

ORAL HYPOGLYCEMIC AGENTS—WHERE DO WE GO FROM HERE? John A. Owen, Jr., M.D.	1
CORONARY CINEARTERIOGRAPHY IN THE DIAGNOSIS OF ARTERIOSCLEROTIC HEART DISEASE Arnoldo Fiedontin, M.D.	6
LESIONS OF THE OMENTUM Bhongtep Singhabhandhu, M.D., Charles Ritz, B.S., M.S., Stephen W. Gray, Ph.D., M. D. Vohman, M.D., F.C.A.P. and John E. Skandalakis, M.D., Ph.D., F.A.C.S.	9
ANTERIOR CERVICAL DISC EXCISION AND FUSION Hugh S. Thompson, Jr., M.D.	14

Editorials

GOVERNMENT REORGANIZATION AND THE PHYSICIAN	18
EMCRO: A PEER REVIEW MECHANISM	36
PEER REVIEW John R. McCain, M.D.	16A

Features		The Association	
President's Letter	19	New Members	25
Cancer Page	20	Personals	25
Heart Page	22	Deaths	25
Month in Washington	26	Societies	17A

The author presents a comprehensive review of this complex and unresolved problem.

JOURNAL
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Georgia

Oral Hypoglycemic Agents Where Do We Go From Here?*

JOHN A. OWEN, JR., M.D.,[†] Charlottesville, Virginia

THE CHOICE OF this topic for discussion in 1971 is clearly and deliberately controversial, implying that we have crossed some sort of a watershed in our use of oral antidiabetic agents. But it is also clearly premature, for the controversy surrounding the University Group Diabetes Program still rages and the time has not yet come to pronounce the obituary of sulfonylurea drugs and biguanides. Nevertheless, we cannot continue to follow this immoderately public and prolix debate without sooner or later yearning for therapy which would be just a little less controversial, which in turn leads to a restless kind of speculation concerning the future. This need not be futile. Already there are enough scattered straws in the wind to permit a limited look at some future therapeutic approaches to diabetes mellitus, regardless of the eventual outcome of the UGDP study. Emphasizing the new and different, this review specifically excludes newer sulfonylurea or biguanide drugs.

Interestingly enough, there are a number of oral agents which have proven hypoglycemic in the laboratory, although clinical studies are still unreported. The senior citizen on this list is probably hypoglycin, the amino acid component of the ackee, a Jamaican fruit. Captain Bligh apparently imported this tree to Jamaica and thus provided its name, *Blighia sapida*. Hypoglycin is only present in the unripe fruit, which explains why spontaneous hypoglycemia rarely occurs. However, in times of great privation, natives have eaten the unripe ackee and become victims of the Jamaican vomiting sickness,¹ which in-

cludes severe hypoglycemia, sometimes fatal. A recent review by Bressler et al.² indicates the site of action of hypoglycin to be an inhibition of fatty acid oxidation. The utilization of glucose increases in peripheral tissues, perhaps in order to meet the energy needs of the organism; there is also a block in gluconeogenesis and the blood sugar falls precipitously. Unfortunately for our therapeutic hopes, any beneficial therapeutic effect in hyperglycemic states would be offset by the toxic depression of intracellular coenzyme A, and thus it appears unlikely that hypoglycin will ever be used clinically.

Like modern manna from heaven, two different hypoglycemic plant substances have been reported recently from the Middle East, each with some limited possibilities. The first of these is a fairly venerable folk remedy which, of course, is in itself always reassuring. The shepherds of Syria have long known that a decoction of boiled roots of the common desert herb, *Poterium spinosum*, was quite efficacious in the therapy of human diabetes. Attempts to confirm this impression have produced quite inconsistent results, but a recent paper by Shani (Mishkinsky) et al.³ suggests the reason. Apparently, it is only during May and June that a hypoglycemic substance can be found in the root bark of *Poterium spinosum* (Figure 1). The extract is effective when given by mouth to alloxan diabetic rats, opening the way for the sophisticated studies necessary to identify this substance and to test it systematically in diabetic humans. So far no studies have been undertaken to investigate the chemical nature of this agent.

Even more interesting has been a recent inquiry into the life and habits of the desert rat, *Psammomys obesus*, which flourishes in the deserts of North

* Presented at the annual meeting of the Georgia Diabetes Association, Atlanta, May 13, 1971.

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HYPOGLYCEMIC AGENTS / Owen

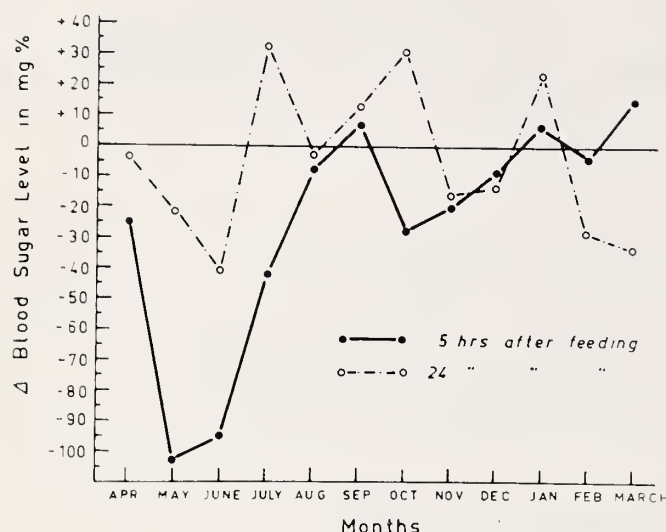


FIGURE 1

Seasonal variations in hypoglycemic potency of *Poterium* extract in alloxan-diabetic rats (reproduced by permission from Arch. Int. Pharmacodyn. Ther. 185:344, 1970).

Africa and the Middle East where food is sparse and water is almost nonexistent. When captured and given unlimited access to good laboratory chow and water, *Psammomys* rapidly becomes diabetic, thus telescoping in a few short weeks the entire pathogenesis of human maturity-onset diabetes. It has been previously assumed that this was due to dietary overindulgence in a genetically predisposed animal. Aharonson et al.⁴ considered the intriguing alternative that the desert rat becomes diabetic, not because of the debilitating effects of rich food, but perhaps because it lacks some vital nutrient found in its native habitat. Sure enough, when these authors investigated the burrows of *Psammomys obesus* in southern Israel, they found chewed-up fragments of plants which were identifiable as *Atriplex halimus*, the Dead Sea saltbush. Needless to say the next step was to prepare an aqueous extract of *Atriplex*; when this extract was administered orally it produced marked hypoglycemia in alloxan-diabetic, but not in normal rats. The protective factor in these extracts has not been identified as yet, but they contain high concentrations of sodium and potassium. While these ions undoubtedly are not crucial in preventing the development of diabetes, they may facilitate the action of other *Atriplex* components. (Incidentally, chromium has been implicated as a factor which improves glucose tolerance in animals and perhaps in man, but none was found in extracts of *Atriplex halimus*.) Since the natural supply of both *Poterium* and *Atriplex* is quite limited, the basic hypoglycemic substances, if clinically useful, would certainly have to be synthesized to be effective on a wide clinical scale.

Another agent under active investigation (at Lederle Laboratories) is the synthetic compound, 1-methyl-4-(3-methyl-5-isoxazolyl) pyridinium chloride, which has been reported to cause hypoglycemia in alloxan-diabetic animals.⁵ The authors express the hope that this drug may have some potential as an antidiabetic agent in man, but no clinical studies have been reported so far, which is certainly not encouraging. Nevertheless, pyridinium may still be a name to conjure with in the future.

The next compound is not an oral hypoglycemic agent but one which deserves attention because of its potentially important role in both the pathogenesis and the treatment of diabetes. Bornstein and his colleagues have reported a series of studies on fractions of human growth hormone.⁶⁻⁹ They have isolated one fraction which has an inhibitory effect on glucose oxidation and triglyceride synthesis and therefore acts as a diabetogenic hormone; this is termed inhibitory growth hormone (In-G). The other fragment appears to do exactly the opposite by removing the inhibition and is therefore called accelerator growth hormone (Ac-G). The accelerator hormone is capable of potentiating the action of insulin in normal human subjects, as well as lowering blood sugar in diabetic subjects. Furthermore, a group of diabetics were found to have increased serum levels of inhibitory growth hormone after glucose stimulation, whereas normal subjects had decreased serum levels of both the inhibitory and accelerator growth hormone under the same conditions. Thus we have a possible diabetogenic factor as well as possible antidiabetic therapy, both fragments of the same natural pituitary hormone. Whether purification of Ac-G polypeptide would produce a compound with therapeutic potential is as yet unknown. Whether this could be synthesized and administered with benefit to a significant number of diabetics is an even bigger question which obviously waits upon the first.

But a really clear-eyed look into the future requires that we stop at this point and ask whether we should continue the time-honored habit of equating antidiabetic effect with hypoglycemic effect. After all, the UGDP showed that insulin in variable dosage was the most effective program for keeping the blood sugar down.¹⁰ On the other hand, the statistics from that study also showed that patients receiving no drugs at all, whose hyperglycemia had returned to its former levels, had an overall survival which was no worse and perhaps a little better than even those insulin-treated diabetics with normal blood sugar. Thus one would conclude that hyperglycemia per se is not a threat and requires no treatment. This is, of course, the crux of the question the UGDP set out to answer, a question which is still unan-

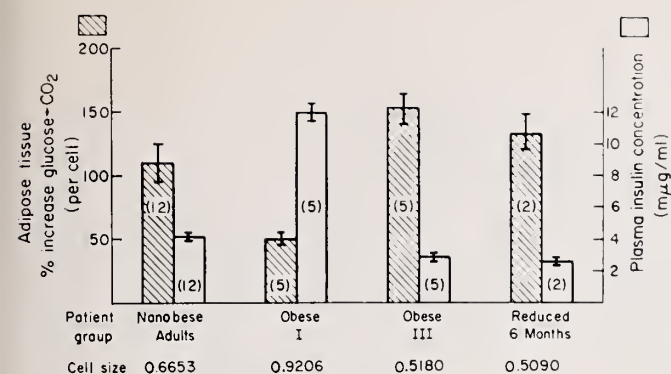


FIGURE 2

In vivo insulin concentrations and in vitro adipose tissue and cell size in normal individuals and in obese (I) and reduced obese (III) subjects. Obese I subjects generally had impaired glucose tolerance which improved or normalized after reduction of excess weight (obese III) (reproduced by permission from J. Clin. Invest. 47:153, 1968).

answered. While we wait, let us consider a more basic approach to the whole diabetic spectrum and not just modalities which merely lower the blood sugar.

One such approach is to focus on one of the obvious pathogenetic mechanisms in the development of maturity-onset diabetes: For most of these individuals obesity is the mother of diabetes, which is another way of saying that diabetes is essentially a nutritional disease.¹¹ Everyone knows how futile it is to attempt lasting weight reduction in any form of obesity. The majority of obese patients never lose as much as 20 pounds; those who do are all too prone to regain it within two years.¹² Yet almost invariably weight reduction dramatically improves glucose tolerance in middle-aged diabetics. Why can't we achieve better cooperation in an approach which so obviously works? This above all is the greatest frustration in caring for adult diabetes.

Perhaps we can gain some appreciation of our limitations from the studies of Salans et al. at the Rockefeller Institute.¹³ It is clear from their work that impaired glucose tolerance is associated with obesity, and that this is mediated through increase in the size of adipose tissue cells (Figure 2). When the patient reduces, the size of each cell reduces, endogenous insulin becomes more effective, and glucose tolerance is improved. However, when and if the subjects regain their weight, the adipose tissue cells increase in size, and their membranes again become resistant to the action of insulin. An animal model for this phenomenon has been provided in another study¹⁴ in which litters of inbred rats were rearranged shortly after birth, so that some mothers ended up with 22 pups and some with only four. The resultant discrepancies in access to mother's milk predictably left the rats in the 22-animal litters somewhat scrawny and underweight as compared to the more fortunate siblings in the smaller litters.

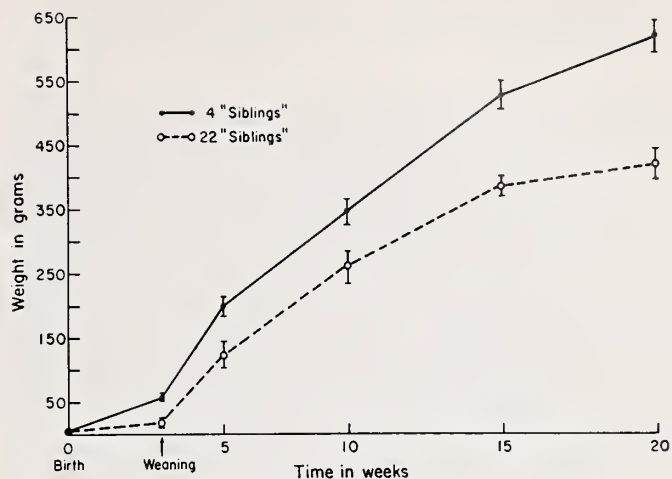


FIGURE 3

Body weight of rats from large and small litters, after weaning (reproduced by permission from J. Clin. Invest. 47:2091, 1968).

At the time of weaning all animals were separated, housed individually, given equal and unlimited access to food and water. Nevertheless this early difference in body weight was maintained and even enhanced throughout the rest of life; fat biopsies indicate that the bigger animals always had bigger adipose tissue cells and more of them (Figures 3 and 4).

If these findings can be applied to human growth and development, we may infer that there is an influence in neonatal life which stimulates the replication of a larger number of adipose tissue cells and that this superabundance of cells per se constitutes the basic defect which predisposes to obesity, just as the engorgement of these cells with triglyceride predisposes to diabetes. Pediatricians are now be-

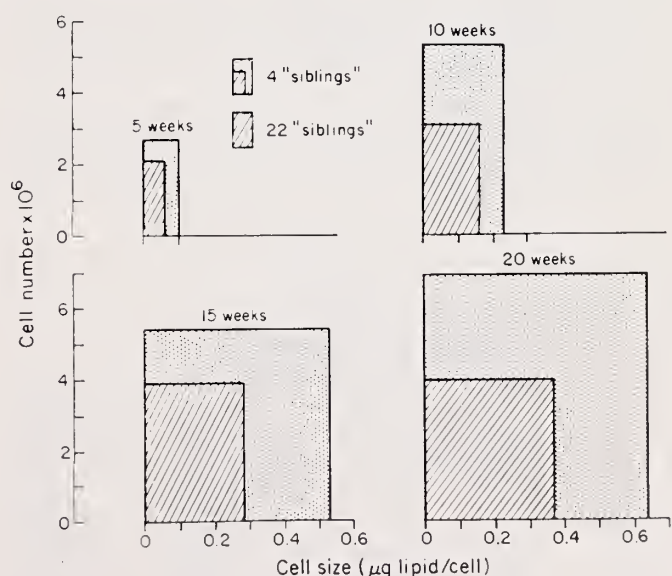


FIGURE 4

Adipose tissue cell number and size from rats shown in Figure 3 (reproduced by permission from J. Clin. Invest. 47:2091, 1968).

ginning to investigate the nutritional factors which may be operant, even though it may take 20 years or more before the adult physique will confirm or disprove predictions made during infancy. At present we can only say, on somewhat scanty evidence at that, that there is no greater handicap than to begin life as a fat baby. And yet the factors which produce a fat baby are perhaps as complex and elusive as those which we have previously sought in fat adults.

Admittedly, the large-scale prevention of obesity as a means of preventing diabetes must be one of the most difficult and unrewarding endeavors that a man might choose for himself. But unless the pathogenetic chain of events can be broken somewhere, the long-term prospects are depressing indeed. With considerable help from the U.S. Public Health Service¹⁵⁻¹⁷ it has been possible to review our national diabetic situation in 1965 and 1969 and to project what this will mean to our population in 1979. This prediction assumes future demographic characteristics on the basis of findings in previous census surveys. More important, it assumes linear increases in the incidence and prevalence of diabetes, in continuation of the trend and in proportion to the rate at which these have increased in the past. These calculations would indicate that by 1979 the number of total diabetics, known and unknown, in the United States will be about 38 per 1,000 population, as compared to 18 per 1,000 in 1960 (Tables I and II). Furthermore, in terms of the predicted number of practicing physicians who will be offering primary care of diabetes, the patient load per physician will triple, from about 40 to over 125 patients. If one likes to play with figures it is possible to extrapolate this increase into the future and predict that by the year 2853 A.D. every person in the United States will become diabetic, a population which by then may number 3,200,000,000 people.

TABLE I
DIAGNOSED DIABETES: 1979

Age	Rate Per 1,000			Population, 1979	Diabetic in 1979
	1959-61	1965-66	?1979		
0-24	1.0	1.6	2.8	112,872,000	316,042
25-44	5.0	8.0	14.0	60,147,000	842,058
45-54	15.2	20.0	34.4	22,470,000	772,968
55-64	31.4	45.7	98.6	20,814,000	2,052,260
65-74	42.4	64.4	121.0	14,235,000	1,722,435
75 +	37.5	57.9	119.1	8,466,000	1,008,301
Total				239,004,000	6,714,064

TABLE II
UNDIAGNOSED DIABETES: 1979

Age	Rate Per 1,000			Population, 1979	Diabetic in 1979
	1959-61	1965-66	?1979		
0-24	0.7	0.7	0.7	112,872,000	79,010
25-44	5.2	5.2	5.2	60,147,000	312,764
45-54	17.9	20.6	28.7	22,470,000	644,889
55-64	24.2	24.2	24.2	20,814,000	503,699
65-74	26.2	26.2	26.2	14,235,000	372,957
75 +	24.5	24.5	24.5	8,466,000	207,417
Total				239,004,000	2,120,737

This is, of course, a super-nightmare. But when we awaken, let us ask ourselves again: Is 1971 too early to begin the search for a nutritional prophylaxis against the ever-increasing numbers of obese middle-aged diabetics that we see every day?

Before answering that question, let us examine one final project that deserves considerable comment. Years ago, Dr. Charles Best did some crystal-gazing about the future developments in the management of diabetics.¹⁸ He spoke of the miniaturization of equipment used to measure blood sugar and to dispense insulin automatically, and speculated that the time might come when two such devices might be coupled so that changes in circulating blood sugar could modulate the rate of delivery of crystalline insulin from a plastic reservoir into the circulation. The entire module was conceived as an implantable mechanism, not as small as a pacemaker, but not so large as an artificial kidney. In fact Dr. Best thought it might fit neatly into the space provided by a splenectomy, utilizing the idle splenic vein and artery for plumbing connections. Only recently we have all read of the breakthrough achieved by the group working with Dr. Bessman at U.S.C.: A tiny power cell has been developed which will provide the energy necessary to perform the continuous measurement of blood sugar inside the body (Figure 5). It should not be too difficult now to link this to a system for the metered delivery of insulin into the circulation in response to blood sugar fluctuations.¹⁹ So the artificial pancreas probably looms closer on the horizon for diabetics than we would have dreamed a few months ago, making it safe to predict that most of us will see some carefully selected diabetic patients fitted with an artificial pancreas within the next ten years.

Americans have been famous for their ability to hurl all of their enthusiasms and energy into a breakthrough project. The moonshot concept epitomizes this spirit and represents one of our greatest national characteristics. On the other hand the steady, persistent inner discipline to deny ourselves those

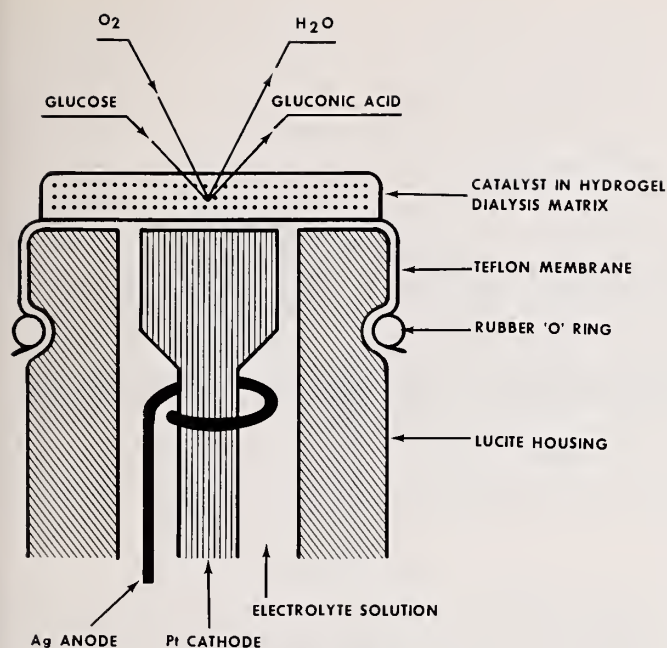


FIGURE 5

Inorganic catalyst membrane electrode (Clark type) for monitoring oxidizable sugar in body fluids (reproduced by permission of Drs. Bessman and Schultz).¹⁹

things which are pleasant, available, and debilitating, is not an outstanding American characteristic. Given the problems of designing an artificial implantable pancreas versus the problem of persuading American mothers not to make their babies fat, it is crystal clear which is a fascinating and achievable goal and which is not. The time may come when the lucky diabetic is the one who develops insulin-deficient diabetes before age 30 and thereby becomes eligible for an artificial pancreas. The middle-aged obese diabetic with persistent endogenous insulin secretion is going to remain an ever-growing medical and perhaps political problem. Let's hope some dynamic, idealistic, charismatic statesman will not one day wage a presidential campaign on the platform of an artificial pancreas for every middle-aged American voter! This is another nightmare, but to what will we awaken?

After oral hypoglycemic agents, where do we go from here? I don't know. All drug therapy is, after all, an attempt to catch up with a metabolic *fait accompli*. The real challenge, the unlimited opportunity, is in the prophylaxis of diabetes. Perhaps we need to endure some therapeutic disappointments in order to finally get excited about prevention.

University of Virginia School of Medicine

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This procedure should be considered in every patient in whom the diagnosis of coronary artery disease enters the differential diagnosis.

Coronary Cinearteriography in the Diagnosis of Arteriosclerotic Heart Disease

ARNOLDO FIEDOTIN, M.D., *Atlanta*

THE DIAGNOSIS of coronary atheromatous disease has classically depended on the subjective evaluation by the physician of chest pain described by patients with infinitely variable subjective response to stress. Since Heberden's description of angina, we have always relied on the patient's sensation of sub-sternal constrictive distress produced by exercise and relieved by rest as the principal manifestation of myocardial ischemia. We continue to insist and, justifiably so, in the clinical syndrome, and have long ago learned to accept our failures at diagnosis with resignation.

Our diagnostic ability was greatly enhanced with the development of electrocardiography and this progressed even farther with the advent of the exercise electrocardiogram. Despite our increasing sophistication, we still accept the rather frequent "false positive" and "false negatives" within the context of our ability to diagnose coronary atheromatous disease. Because of these limitations in clinical practice, we have been able to recognize this disease in our patients only after it has progressed to the point of obstruction severe enough to produce transient or permanent secondary changes in the left ventricular myocardium. These diagnoses are, of course, based upon recognition of the complications of coronary atherosclerosis, rather than upon objective demonstration of the presence and extent of the primary arterial disease. The limitations imposed by these diagnostic criteria have been responsible for the production of iatrogenic disability on one hand and unjustified reassurance to patients with eminently fatal disease on the other.

Obviously, a safe, definite and reproducible method for demonstrating the physical characteristics of the human coronary artery tree, which could

be used in any phase of the natural history of this condition in the living human being, was needed to provide a more dependable diagnostic standard for the recognition of coronary artery disease. During the last 11 years, selective coronary cinearteriography has filled that gap and has become the most accurate diagnostic test currently used for diagnosis of coronary arteriosclerosis.

The test is carried out in the Cardiac Catheterization Laboratory, which has an especially adapted X-ray equipment with image intensification system, coupled to a TV chain and high-speed 35 mm. cinematography. The patient lies on an electrically-operated rotating cradle which allows for the easy performance of the test in different projections. The electrocardiogram is constantly monitored in a special oscilloscope and these variables can be recorded by a special camera whenever indicated. Two defibrillators are always fully charged during performance of the test as a safety measure. The studies are also recorded in a videotape machine to permit instant playback and as an extra precaution, in case of difficulty in the developing of the film. The most important factor, however, is the high quality, motivation, and capability of the nursing personnel in the laboratory. No amount of electronic gadgetry can replace their experience.

When the patient comes to the catheterization laboratory in the morning, he is placed in the rotating cradle and ECG electrodes are connected. A cutdown is performed in the right antecubital fossa, after premedication with phenobarbital and usually penicillin, and a specially designed catheter with a tapered end is advanced retrograde via the right brachial artery into the left ventricle. Pressures are recorded in that chamber and on pullback to the aortic root. Both coronary arteries are then selectively opacified in several projections, using radiopaque contrast material, to permit visualization of the entire coronary arterial tree down to branches

of approximately 300 microns in diameter, and their appearance is recorded in 35 mm. film, at 60 frames/sec. A left ventriculogram is always performed as an integral part of the procedure in order to evaluate the status of the left ventricular myocardium and the mitral valve apparatus. The catheter is then withdrawn and the artery sutured to maintain blood flow.

The procedure usually takes one hour for completion and the patient is returned to his room, where he is served breakfast or lunch. When the test is performed as an out-patient procedure, the patient is observed in our Short Stay Service for a few hours and then is discharged in the afternoon.

Indications

Except for obvious situations, which will be touched upon later, coronary cinearteriography is indicated on every patient in whom the diagnosis of coronary artery disease enters the differential diagnosis. Putting it another way, there are diagnostic, as well as therapeutic, indications for performing this test. As a diagnostic tool, it is used in case of atypical chest pain. The medical and socio-economic implications of a correct or incorrect diagnosis are so obvious that I need not dwell on the subject. The need for this test becomes even more apparent when an atypical chest pain is accompanied by non-specific ECG abnormalities which are interpreted as being ischemic.

On the other hand, the test is also indicated in patients with classical angina, with or without previous infarction, in order to evaluate the possibility of a myocardial revascularization procedure that may improve myocardial perfusion. As the constantly improving surgical techniques have reached the stage of an accepted approach to coronary artery disease, the number of patients undergoing diagnostic coronary arteriography has been constantly increasing, since the diagnosis of the precise anatomic location of the atheromatous lesions is a fundamental requirement for a logical surgical approach.

To summarize the indications, at the present time selective coronary cinearteriography is routinely performed in all patients in whom the diagnosis of coronary atherosclerosis is suspected, or in whom the diagnosis has been established on the basis of clinical grounds, when there is reason to believe that surgical intervention may offer benefit to the patient.

The studies are not performed for two to three months following an acute myocardial infarction, if the patient is obese and will tax the capabilities of the radiographic equipment, or if there is congestive heart failure which may be controlled by adequate medical management. It is not routinely per-

formed in patients beyond the age of 70 years, or in patients with diffuse scar tissue replacement of the left ventricular myocardium resulting in gross cardiomegaly due to previous multiple infarctions. However, the study is indicated in patients in whom congestive heart failure may be the result of a ventricular aneurysm, as excision of the aneurysm is accompanied by marked improvement of the clinical picture and, obviously, in these cases, angina need not be present.

It should be emphasized that this is not a study that should be used in terminal cases of the disease when all measures of medical management have failed, but it is most effectively employed at the earliest possible time after the appearance of angina pectoris or electrocardiographic manifestations indicative of myocardial ischemia.

Coronary cinearteriography is performed routinely during diagnostic cardiac catheterization in patients with rheumatic heart disease, especially in severe aortic lesions. It is of interest to note that more and more cardiac surgeons insist in preoperative evaluation of the coronary artery system in patients undergoing surgery for rheumatic or congenital heart disease. The coronary arteries are also visualized in all patients with ventricular septal defects and tetralogy of Fallot, as major anomalous coronary artery branches have, in the past, been accidentally cut during right ventriculotomy incident to surgical repair of those lesions.

Complications

The mortality associated with performance of this test varies between 0.1 and 0.3 per cent in well equipped and staffed laboratories. We had one death in 800 cases. Higher, and I may add, totally unacceptable, figures have been reported from some centers, but close examination of such institutions have always disclosed that serious technical faults were responsible. As a matter of fact, the higher mortality figures reported with the Judkins percutaneous technique are no doubt related to the fact that the technique is all too simple and therefore inviting to the inexperienced physician lacking the necessary background, with the consequent disastrous results.

The most serious complication of the test is ventricular fibrillation; its frequency has been drastically reduced with the use of Meglumine Diatrizoate as the contrast agent. We have not had a single episode of ventricular fibrillation in the last two years. Nevertheless, the personnel in the laboratory constantly rehearses defibrillation routines, which in the past has allowed us to always successfully defibrillate a patient in less than 15 seconds.

As I mentioned, the ECG is constantly monitored by the nurse during this procedure.

Sinus bradycardia is occasionally encountered during the injections, and this responds to explosive coughing, a technique which is taught to the patient prior to the performance of the test. Atropine sulfate, incidentally, is always loaded in a syringe in the catheterization table and it can be injected intra-aortically, if necessary.

Minor allergic reactions to the contrast material have been encountered and they have always responded to Benadryl and/or hydrocortisone. Segmental occlusion of the brachial artery at the site of the arteriotomy occurs in approximately 5 per cent of the patients, but it is very rarely symptomatic and has required thromboembolectomy in only 0.3 per cent, as collateral circulation around the elbow has been adequate to prevent measurable disability or tissue loss. The hazards of selective coronary cinearteriography are quite acceptable, obviously, in view of the objectives obtained.

Summary

Coronary cinearteriography is now recognized as the standard test for the diagnosis of human coronary atherosclerosis against which all other tests are evaluated and, from a therapeutic standpoint, together with direct coronary artery surgical methods (venous bypasses), improve the potential for increased productivity and survival of thousands of our contemporaries.

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*Much of the interest in omental disease
lies in its simulation of acute
appendicitis or gallbladder disease.*

Lesions of the Omentum*

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STEPHEN W. GRAY, Ph.D.; M. D. VOHMAN, M.D., F.C.A.P.; and
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OUR RECENT EXPERIENCES with a few cases of omental pathology have prompted us to examine the literature and report our cases. Much of the interest in omental disease lies in its simulation of acute appendicitis or gallbladder disease. Perhaps because of the improbability of omental disease it is rarely diagnosed before the abdomen is opened.

Development and Physiology

Embryologically the greater omentum forms as a sac of redundant dorsal mesentery of the stomach. The two walls of the sac subsequently fuse to one another and to the anterior surface of the transverse colon and the mesocolon.

Physiologically the function of the omentum is obscure despite numerous investigations and even more numerous speculations. The most recent studies and probably the most extensive were done by Walker and his colleagues (1960, 1963). Five specific functions may be assigned:

- (1) The omentum serves to fix several organs to each other and to the body wall.
- (2) The omentum acts as a reservoir of phagocytes and potential antibodies to large areas of the abdomen and its contents.
- (3) The omentum may wall off focuses of infection by its physical presence.
- (4) The omentum may revascularize areas of impaired circulation in the abdomen.
- (5) The omentum serves to clear abdominal peritoneal and visceral surfaces by actively absorbing particulate material.

The last three functions have been demonstrated in experimental animals and probably, but not certainly, can take place in humans.

Lesions of the Omentum

Among primary diseases of the omentum the following clinical entities have been observed. None are common:

- (1) Infarction and torsion of the omentum
- (2) Cysts of the omentum
- (3) Benign and malignant tumors of the omentum
- (4) Congenital malformations of the omentum

Only lesions of the first two groups have been seen recently at Piedmont Hospital. Six cases, two of infarction, two of torsion, and two of omental cysts will be described.

Case Histories

I. OMENTAL INFARCTION

Case 1. The patient (J. M. 309960), a 73-year-old white male, was hospitalized complaining of intermittent abdominal swelling and dull pain in the left lower quadrant for one week prior to admission. Pain was not related to food nor activity but was associated with mild nausea and vomiting. Previous attacks had been treated conservatively elsewhere. At operation, the abnormal findings were confined to the abdomen which was moderately distended. Some tenderness was present in the left lower quadrant and a mass was palpable. No muscular rigidity or rebound sign was felt. The white cell count was 5,000. At operation, a yellowish-green, firm mass was found at the dependent portion of the omentum. After excision it measured 2½ inches in diameter. The pathologic report was an area of fat necrosis. This area was infiltrated by lymphocytes, plasma cells, pigment-laden macrophages, and giant cells. Some fibrosis was seen. The patient's postoperative recovery was uncomplicated.

Case 2. The patient (L. P. 305337), a 72-year-old white female was admitted to the hospital complaining of malaise, rhinorrhea, and generalized

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body ache for five weeks. She had atrial fibrillation and had been on Digoxin for several years. She had a history of hypertension and stroke five years ago. A right carotid endarterectomy was performed and she recovered from hemiparesis. On admission the patient appeared in marked respiratory distress. She became lethargic and developed generalized abdominal pain with severe tenderness on the third day. The abdomen was rigid and the rebound sign was present all over. Surgical and urological consultations were made and the general impressions were acute abdomen probably secondary to mesenteric thrombosis and pre-renal failure. On the following day, she became polyuric with urinary output of about two liters. The abdominal findings remained unchanged and her mental condition deteriorated. She was then explored and at operation, a large amount of bloody fluid was found in the abdomen.

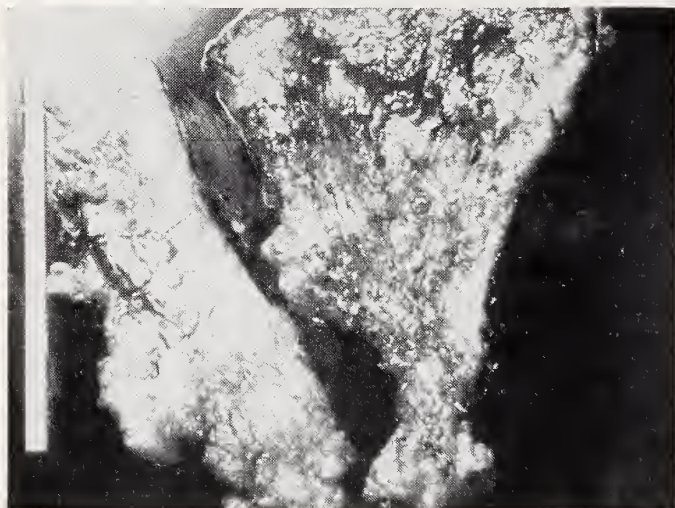


FIGURE 1

Omental infarction, Case 2. The hemorrhagic, edematous mass was removed from the free edge of the omentum.

On the free edge of the omentum, there was a hemorrhagic and edematous mass measuring four inches in size (Figure 1). Right salpingo-oophorectomy and omentectomy were performed. Pathological reports were thecoma and serous cystadenoma of the right ovary and right hydrosalpinx. Microscopic examination of the omentum presented evidence of polyarteritis nodosa involving small arterioles characterized by thrombosis, fibrinoid degeneration of the wall, and heavy infiltration of inflammatory cells in the perivascular tissue extending into the media and intima. Postoperatively the patient developed myoclonic seizures, lapsed into unconsciousness, and expired on the seventh postoperative day. Autopsy permission was not granted.

Case 3. The patient (H. E. 297908), a 35-year-old white male was admitted to the hospital with the complaint of severe right-sided abdominal pain for three days. The pain became worse and he was nauseated. He had been told many years ago he had a gastric ulcer and had noted a feeling of indigestion and dull postprandial pain for three months. Upper gastrointestinal series, intravenous pyelogram, and gallbladder series were done. The gallbladder was not visualized. The only abnormal findings were severe pain and tenderness with muscular rigidity and rebound on the right side of the abdomen. White blood cell count was 11,900 c.mm. The diagnosis of acute cholecystitis was made and exploration was undertaken. A moderate amount of bloody fluid was found on opening the peritoneum. The appendix and gallbladder appeared normal. A reddish-brown mass, three by six inches, on the right side of the omentum (Figure 2) was twisted and adherent to the ascending colon. The mass was excised; microscopic examination showed hemorrhagic infarction characterized by a large area of hemorrhage, dilatation of the vascular channels, and foci of necrosis and inflammation. The patient was discharged later with no complications.

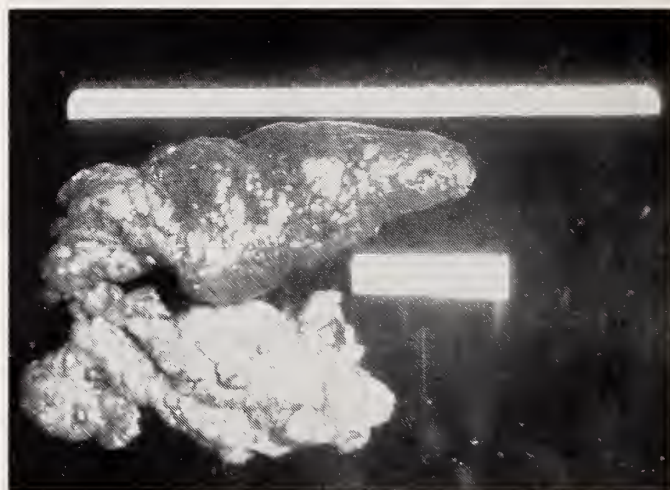


FIGURE 2

Omental torsion, Case 3. The large twisted mass of omentum was hemorrhagic, inflamed, and necrotic.

Case 4. The patient (S. K. 278476), a six-year-old white boy was admitted complaining of dull abdominal pain in the right lower quadrant for three days prior to admission. The pain increased in degree and frequency on the day of admission. He was nauseated and vomited several times. The white cell count was 7,500. The pertinent findings were limited to the abdomen which was tender in the lower right quadrant, without muscular rigidity or rebound. The patient was operated upon with the suspicion of acute appendicitis. At operation, the right side of

the omentum was found twisted. The appendix was normal. Appendectomy and excision of the omental mass were performed. This mass was on the dependent portion of the right side of the omentum, dark red, and three by one by one inches in size.

Discussion

Omental infarction may be primary or it may be the result of torsion. The most convenient classification is that cited by Takita (1965) and extended by Anton and his colleagues (1945):

A. Omental infarction due to thrombosis

This may be of inflammatory, traumatic or idiopathic origin. Hernia or adhesions may be implicated.

B. Omental infarction due to torsion.

1. Primary, of idiopathic origin.

2. Secondary, due to hernia, adhesions from previous surgery, or from other abdominal or pelvic disease.

Our Cases 1 and 2 belong to Group A. Such cases are rare. The first case was described in a man suspected of appendicitis in 1920 by Eberts. By 1965 only 90 cases were in the literature.

Our Cases 3 and 4 belong to Group B1, torsion, which takes place in the absence of other abdominal disease. First described in 1899 by Eitel, more than 165 cases have been reported. By contrast, omental torsion of Group B2 secondary to surgery or disease is very common.

Many diverse theories have been developed to explain the etiopathogenesis of omental infarction. Rabinovitch and Pines (1940) advanced a theory, following their experiments in rabbits, which attributed venous thrombus formation, the leading cause of the infarction, to the stretching of the omental vein. Totten (1942) believed that any increased intra-abdominal tension such as sneezing, straining, coughing following meals, may lead to the rupture of some dependent engorged veins of the omentum and cause hemorrhagic extravasation and a secondary thrombosis.

Payr (1906) explained idiopathic torsion of the omentum as a result of the twisting of engorged veins around the tense artery of the omentum. The omental veins are larger, longer and more tortuous than the arteries and hence may be easily compressed by any condition causing increased intra-abdominal pressure.

As increased abdominal pressure is a frequent, daily occurrence in the human body, these mechanical explanations seem implausible unless there are contributing causes, either in the form of the omentum or in the walls of the blood vessels as in our Case 2. Much as the term "idiopathic" bothers the medical scientist, he must be suspicious of facile

explanations which serve only to relieve his discomfort!

Pathological Picture

Primary infarction and primary torsion have a similar microscopic and macroscopic picture. The affected area appears hemorrhagic, edematous, and gangrenous. Microscopically, there is venous congestion, thrombosis, and extravasation of the blood within the necrotic fatty tissue. The area is also infiltrated by inflammatory cells, mainly leukocytes.

Symptoms

Because of their rarity, infarction and torsion of the omentum are not usually included in the differential diagnosis of the acute abdomen. Both conditions may easily be mistaken for appendicitis or cholecystitis. Among 165 cases of primary omental torsion, 72 per cent were diagnosed as acute appendicitis; 11 per cent as acute cholecystitis (Mainzer and Simoes 1964).

Diagnosis

Most patients with omental infarction or torsion present with fever, tachycardia, and right lower quadrant pain. The pain usually begins suddenly, and is constant following meals or during physical exertion. The pain may be diffused, but in two thirds of patients it is localized in the right lower quadrant. The duration of the pain is longer than in appendicitis, sometimes as long as four to five days prior to admission. Frequently absent in the torsion patients are gastrointestinal symptoms such as diarrhea, nausea and anorexia.

Fever of over 101° F was found in only 11 of 165 patients with primary torsion (Mainzer and Simoes 1964). Leucocytosis in excess of 12,000 was found in two thirds of the cases. An intra-abdominal mass can be felt in one third of patients examined.

Muscular rigidity and other peritoneal signs are not frequent. Serosanguineous fluid and bloody fluid in the abdomen commonly accompany omental infarction. Primary infarction affects males and females equally; those affected are usually between 20 to 55 years of age. Among 165 cases of primary torsion, there were 91 males and 64 females. There were more children in the primary infarction group (21 per cent) than in the primary torsion group (15 per cent). The difference is probably not significant.

Treatment

Because the symptoms of omental infarction and torsion mimic those of acute abdominal inflammation, abdominal exploration is usually necessary. Resection of the affected omental tissue is the only accepted treatment. Untwisting the torsion for drainage of the infarcted area cannot be recommended.

III. OMENTAL CYSTS

Case 5. The patient (L. M. 95688), a 34-year-old white female, gravida nine, para three, was admitted complaining of pain in the right side of the abdomen and history of dysmenorrhea for seven years starting approximately one year after her last delivery. Pain was steady, dull, and subsided spontaneously. She had appendectomy and tubal ligation at the ages of 10 and 26. The pertinent positive findings were some tenderness and a vaguely felt mass in the right lower quadrant. This mass was also palpable in the right adnexa. She underwent an exploration for this mass and a dilatation and curettage. At operation the left ovary was found to contain a cyst measuring two inches in diameter; the right ovary also had a smaller translucent cyst. There was a third clear cyst, two inches in size at the tip of the omentum. Resection of the omental cyst, left oophorectomy and right partial oophorectomy were done. Microscopic examination showed the right ovarian cysts to be follicular, and the left ovarian cyst to be luteal. The omental cyst had a thin fibrous wall lined with low cuboidal epithelium and the fluid content was clear. Her postoperative course was uneventful.

Case 6. The patient (T. C. 232559), a 46-year-old white female, gravida three, para three, entered the hospital complaining of heavy menstrual flow lasting more than six days. She had cesarean section in 1952. The only positive findings were irregular and enlarged uterus. No masses were palpable. Total abdominal hysterectomy, left salpingo-oophorectomy, and right salpingectomy were performed. At operation, the uterus was enlarged, with multiple leiomyomas. The left uterine tube had a firm nodule and multiple cystic structures. The right ovary was cystic and a small cystic hydatid was attached by a thin fibrous stalk. An incidental finding was a thin-walled cyst at the tip of the omentum two-thirds inch in diameter. This cyst was excised. Its fluid content was yellowish, clear. The lining of the cyst wall was composed of one to two layers of flat to cuboidal cells. The nature of the cyst was not determined.

Discussion

Gairdner first described an omental cyst in 1851; since then more than 100 cases have been reported. With some exceptions they are similar to cysts of the mesentery and mesocolon because of the common origin of these structures from the primitive dorsal mesentery. Cysts of all kinds are less frequent in the omentum because cystic duplications of the gut

are limited to the mesentery and mesocolon, and cystic remnants of urogenital origin are retroperitoneal or at the mesenteric root. Burnett and his colleagues (1950) found only four lymphatic cysts in the omentum compared with 93 cysts in the mesentery of the small intestine.

Although most omental cysts are described as lymphangiomatous, their origin is not proved. The late onset and rapid growth of many such cysts has encouraged belief in an acquired rather than a congenital origin. Nevertheless the experimental obstruction of lymphatics have failed to produce cysts (Lee 1942).

Pseudocysts, infective or malignant (Beahrs and Dockerty 1950), occur occasionally and dermoid cysts are known (Mumey 1928). It is quite possible that the latter may become detached from the ovary and subsequently adhere to the omentum.

The typical lymphangiomatous cyst is unilocular or multilocular, containing fluid varying from watery to gelatinous, milky or bloody. The cyst wall is usually fibrous and may contain a few muscle fibers. The epithelium may be squamous, cuboidal, or it may be absent due to pressure necrosis (Skandalakis 1955). In our cases the walls were of cuboidal epithelium and the contents were clear.

Symptoms

The primary complaint is abdominal distention of long duration and dull, constant pain. Some patients present gastrointestinal and genitourinary symptoms secondarily caused by pressure from the cyst. Sudden onset of severe pain may follow torsion or rupture of the cyst, hemorrhage into the cyst, or a secondary inflammation. Physical examination may reveal a palpable, soft cystic mass. Omental cysts are ordinarily mobile, similar to long pedicled ovarian cysts. The manipulation of the cyst does not as a rule induce the motion of the uterus. Radiologically, the cyst may appear homogenous with sharp and regular margins. The mass may change in its contour, level and position in relation to other organs when the films are taken in various positions. At times, an intravenous pyelogram, upper gastrointestinal series, small bowel series, or barium enema may demonstrate the organ displacement.

The exact nature of the two simple omental cysts reported here is not clear. They have identical macroscopic and microscopic appearance. They are unilocular, with a thin fibrous wall lined with one or two layers of low cuboidal epithelium. They are not apparently endothelial as might be expected from Lahey's classification (Lahey 1934). By Peterson's classification of nearly 40 years ago, these cysts belong to the pseudocyst group. This is highly improbable.

We feel that the present classifications of simple

cysts of many abdominal organs is of little use in determining the origin, predicting the course, or suggesting the treatment of these uncommon, but not rare lesions.

Treatment

Because of the symptoms, abdominal exploration of the patient is justified. The treatment of choice is excision of the cyst and adjacent omentum. In the present state of our knowledge, wide resection is mandatory. Partial resection of the gut or other organs adherent to the cyst as the result of secondary inflammation or malignant infiltration may be inevitable.

Summary

Six cases, illustrating three lesions of the greater omentum are presented.

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Anterior Cervical Disc Excision and Fusion

HUGH S. THOMPSON, JR., M.D., *East Point*

THE PROBLEM OF NECK, shoulder, arm, and hand pain has been, and continues to be, a difficult diagnostic problem. There are many causes which invade the realm of a wide variety of specialists and general practitioners. These include cervical rib syndrome, anterior scalene syndrome, hyperabduction syndrome, costoclavicular syndrome, minor and major causalgias affecting the upper extremity, Sudeck's atrophy, acroparaesthesia, carpal tunnel syndrome, cervical arthritis, cervical disc rupture, cervical disc degeneration, and post-traumatic conditions such as malunion and subluxation of the cervical vertebrae.

Anterior disc excision and fusion has become available for the treatment of lesions involving the discs, degenerative localized arthritis and spur formations. Also, it is a less traumatic method of cervical fusion in cases of instability resulting from fracture-dislocations.

This article outlines the results in 15 patients followed from two months to three years. There are six male and nine female patients. A discogram was done at the time of surgery in all patients and a cervical myelogram in nine. The myelogram was definitely positive in two cases. All were improved with little or no pain or disability, except for one who had a fusion at three levels. She developed a non-union and later a repeat fusion was performed with good results. There were no operative complications.

There were six patients with a history of a gradual onset. Eight had a definite history of trauma and five were involved in rear-end collisions. One patient had a loose disc fragment removed.

The symptoms in most of these cases consisted of head and neck ache and pain in the shoulder with occasional radiation into the hand. Frequently, the most comfortable position is one of abduction and external rotation of the arm, similar to the salute position.

Lesions involving the discs between the fifth and sixth cervical vertebrae and between the sixth and seventh vertebrae are most common. Lateral herniations of the discs between C5 and C6 usually compress the sixth cervical root. Those between C6 and C7 compress the seventh cervical root and those much rarer herniations between C7 and T1 compress upon the eighth cervical root.

Fifth cervical disc lesions frequently exhibit pain in the neck, top of the shoulder, vertebral border of the scapula and occasionally the anterior chest and outer aspect of the arm and into the thumb. Also, there may be numbness of the thumb, weakness in elbow flexion and decrease in the biceps reflex.

Sixth cervical disc compression of the seventh cervical nerve root also causes pain in the neck and shoulder, pain of the vertebral border of the scapula, outer arm pain, and pain into the index and middle fingers. Numbness of the index and middle finger is often present and weakness of the triceps muscle with decrease in the triceps reflex is noted. This is much more prominent than the changes found in the biceps reflex in C5 disc lesions.

Seventh cervical disc compression of the eighth cervical nerve root are the least common and most difficult to recognize. There is neck and inner arm pain with occasional numbness along the ulna border of the hand and little finger. Usually no reflex changes are found. The lesion is best confirmed by myelography.

The method of operation is essentially that of Smith and Robinson reported in *The Journal of Bone and Joint Surgery* in 1958.

Operation

A left anterolateral transverse incision is made in the lower one-third of the neck, similar to the thyroid incision. The sternocleidomastoid and carotid bundle are retracted laterally, and the trachea and esophagus are retracted medially. The intermuscular plane is relatively avascular. The pretracheal fascia is incised and the anterior spinal column is then visualized. A small needle is inserted in the sus-

pected disc space and a radiopaque solution of hypaque is injected. In a pathological disc, two or three ml. can be injected easily, whereas in a normal disc, only $\frac{2}{10}$ ml. can be injected without considerable force. X-rays are then taken in the operation room and the bone graft is removed from the right iliac crest while the films are being developed.

The pathological disc will show extrusion of the solution laterally and beneath the posterior longitudinal ligament. The most frequently affected areas are the C5 and C6 discs.

The disc is removed by raising a flap of the anterior longitudinal ligament and excising the disc with pituitary rongeurs and curets. The head is maintained in strong traction while the graft is inserted into the disc space. The wound is closed and a Pen-

rose drain is inserted for 24 hours. A plastic collar is worn for six to eight weeks. The usual hospital stay is six to eight days postoperatively.

Summary

A description of anterior cervical disc excision and fusion including the results in 15 patients is given. Some of the more frequent findings are noted. Since this article was prepared, approximately 40 additional patients have been operated upon with essentially the same results.

This operation appears to add considerably to our armamentarium in the treatment of carefully selected patients with neck, shoulder, arm and hand pain.

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CONFERENCE ON PROBLEMS IN PEDIATRIC ANESTHESIOLOGY

The Georgia and South Carolina Societies of Anesthesiologists will present a conference on "Problems in Pediatric Anesthesiology," Saturday, February 26 and Sunday, February 27, 1972, at the Medical College of Georgia Auditorium, Augusta, Georgia.

Subjects to be presented and participants are: "Management of the Pediatric Asthmatic," Russell C. Raphaely, M.D., Medical Director of Inhalation Therapy, Children's Hospital of Philadelphia; "Fluid Administration in Pediatric Anesthesiology," E. Warner Ahlgren,

M.D., Director, Pediatric Anesthesiology, University of Texas Medical School at Dallas; "Toward More Sensible Monitoring in Pediatric Anesthesia," Robert M. Smith, M.D., Director of Anesthesia, Children's Hospital Medical Center, Boston.

Doctors Ahlgren, Raphaely, Smith, and Thomas L. Tidmore, Jr., Chief of Anesthesia, Henrietta Egleston Hospital for Children, Atlanta, will participate in a panel on "Problems in Pediatric Anesthesiology."

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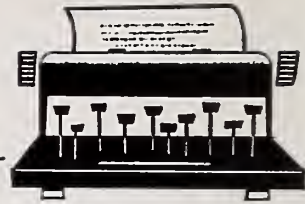
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Government Reorganization and the Physician

G^GOVERNOR CARTER'S proposal to reorganize state government demonstrates beyond doubt the need for physicians to stay in close touch with their elected representatives at all levels of government.

Reflecting the obvious MAG majority position, your *Journal* has previously editorialized against the Governor's plan as it affects health care. It is not the purpose of this editorial to repeat that message. Rather it is to use this legislative crisis to illustrate the absolute necessity for active membership involvement in this or any other matter of interest, if we are to have effective influence on the outcome.

If we object to what is being proposed then it is incumbent upon us to protest. Representative government demands of its citizen a continuous expression. The greater the knowledge possessed by the individual, particularly knowledge of a technical variety needed for the smooth operation of government, the greater the need for that individual to express himself—for or against—issues of public policy.

Let no one assume that somebody else will do your job for you. Number one, they won't, and number two, if they do, it won't be done the same.

Those who wonder why MAG seems preoccupied with urging greater and greater involvement in public affairs will hopefully see in the reorganization crisis the almost perfect illustration of the point. The point being that unless you make your full weight felt government will serve those who do make their weight felt and their voices heard. Unless you write letters, personally call your Senators and Representatives and insist upon a fair hearing, then government will serve those who do.

We wish we could better enjoy the reorganization proposal as a mere academic exercise to illustrate our point. Unfortunately it is much too serious for that. As incredible as it may seem, the medical profession is literally on the threshold of losing control over a vital and significant segment of the practice of medicine. What makes the matter all the worse is the almost certain conclusion that the role of public health will be expanded—very probably into many areas heretofore regarded as areas to be served by the private sector.

None of this need ever happen. It is by no means inevitable. Unless we are willing to fight—write letters, speak to elected officials and do the other necessary communications chores—then the outcome seems totally predictable.

In the idiom of the street, which seems appropriate to the issue, now is the time to put up or shut up.



PRESIDENT'S LETTER

**THE LEADERSHIP AND NEW MEMBERS
CONFERENCE**

BEFORE THE YEAR 1972 has a change to get any older, I want to remind the county and district medical officers of the splendid leadership conference that is coming up February 19 and 20. It is going to be held at the Sheraton-Biltmore in Atlanta. Dr. J. Watts Lipscomb, along with Dr. Tully Blalock and Dr. Norman Berry, has gone all out and put together a humdinger of a program for your benefit. This will be our 14th annual leadership conference. I have been fortunate enough to have attended some six or eight and it was my suggestion two years ago that every new member of MAG was missing the boat if he failed to take advantage of this meeting to learn what the AMA and MAG have to offer—how these organizations operate and the advantages of being a participating member and not just a dues payer. After all, it's from the new members that our future leadership will come and the sooner they get their feet wet the better it will be.

As you know, both organizations have always stood for the preservation of the right of their members to practice free of government control. This stand comes from the house of delegates, and officers, who are elected from the membership. Because both your state and national organizations are so highly visible and because they do not hesitate to speak up in any and all matters of health, they become vulnerable to the slings and arrows of all who seek to change the health care delivery system. These include elected officials and radicals of the new left, those of the extreme right, labor leaders, pressure groups, social planners, and professors. Those who seek changes are not all wrong, for we know that improvements in keeping with the times are essential, but to change the whole system just for the sake of change is wrong and is for the birds. (Oops, I'm about to get to preaching, and getting away from what I started out with—the upcoming LEADERSHIP CONFERENCE.)

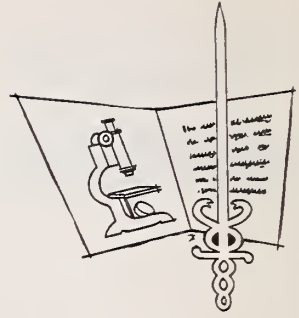
The theme this year is built around "Ecology of Medical Practice." Maybe a better title would be "Who's Putting the Stink in OUR AIR?" I know this is going to be a good conference and you will receive a copy of the program, if you haven't already. Since having the new members join with the county officers is partly my brainchild, I hope they will take advantage of this occasion to learn more about the inner workings. Come, ask questions, and don't let up until you are satisfied and feel that you understand how all the parts of your organization operate. Everyone knows that a better informed membership makes for better members and better future officers and it is from your group (our new members) that these must come.

I'm looking forward to seeing you next month as we discuss THE POLLUTION SOLUTIONS, and

I'll be seeing you.

A handwritten signature in cursive script that reads "W.C. Mitchell".

*W. C. Mitchell, M.D.
President, Medical Association of Ga.*



IMPROVING THE QUALITY OF CARE FOR CANCER PATIENTS THROUGH PROFESSIONAL EDUCATION

JOHN I. DICKINSON, M.D., F.A.C.S.*

WITH THE CONSTANTLY INCREASING body of medical knowledge, the medical profession has always been active in pursuing continuing education. This is nowhere more apparent than in the field of cancer. Seminars, symposia, workshops on prevention, detection, treatment and management of cancer are held throughout the country almost weekly. In an effort to provide an opportunity for Georgia physicians to improve the quality of care for their patients, and to take advantage of the latest information available nearer home, the Professional Education Committee of the American Cancer Society, Georgia Division, presents various professional programs as well as coordinates its efforts with other organizations with the same objectives.

The highlight of the year's professional activity is the "Day of Cancer," which will be co-sponsored for the fourth year with the Atlanta Graduate Medical Assembly, and will be held on Tuesday, March 14, at the Marriott Motor Hotel in Atlanta.

A distinguished faculty has been enlisted, including Robert C. Chambers, M.D., of Baltimore, Maryland; Samuel A. Wells, M.D., of the National Cancer Institute; Edward J. Beattie, Jr., M.D., Chief Medical Officer for Memorial Hospital for Cancer and Allied Diseases; Vincent Collins, M.D., Radiologist in Chief, Rosewood General Hospital, Houston, Texas; and LaSalle D. Leffall, Jr., M.D., Professor and Chairman, Department of Surgery, Howard University School of Medicine, Washington, D.C. John P. Wilson, M.D., Chairman of the Board of Directors of the American Cancer Society, Georgia Division, is the program coordinator for the "Day of Cancer."

Topics to be discussed include: "Selection of Treatment for Head and Neck Carcinoma"; "The Clinical Implications of Immunotherapy and Recent Developments in Cancer Research"; "Problem Cases in Surgical Oncology"; "Radiotherapy—Pre-operative, Post-operative and Co-operative"; and "Diagnosis and Treatment of Polyps and Cancer of the Colon and Rectum." Luncheon discussions with each of the program participants will be a feature of the day, with a Tumor Board Conference to complete the afternoon's activities.

The Cancer Committee of the Medical Association of Georgia has assumed responsibility for the program direction of GRMP's Project 13, which includes Tumor Registries, Area Cancer Facilities, Workshops, and Radiation Therapy Assistants. The Cancer Workshop Committee, composed of representatives of the Cancer Committee of MAG, GRMP, and the American Cancer Society, has

* Dr. Dickinson is Chairman, Professional Education Committee, American Cancer Society, Georgia Division, Inc.

scheduled a series of four Workshops on Cancer for this fiscal year in cooperation with the Area Facility Directors.

The first workshop will be on "Nuclear Medicine" at Emory University on February 10 and 11, with James H. Larose, M.D., Director of Nuclear Medicine at Emory, as the Program Coordinator.

The outstanding faculty includes: C. Craig Harris, M.S., Assistant Professor of Radiology, Division of Nuclear Medicine at Duke University Medical Center; Robert H. Rohrer, Ph.D., Professor of Physics and Radiology at Emory University; Douglas A. Ross, M.D., Ph.D., Research Staff of Oak Ridge National Laboratory; Leonard M. Freeman, M.D., Assistant Professor of Radiology, Albert Einstein College of Medicine, Yeshiva University, Bronx, New York; and Gerald S. Freedman, M.D., Assistant Professor of Radiology, Yale University School of Medicine.

Subjects to be covered include: "Radiation Physics—Decay of Radionuclides and Subsequent Emissions" and "Interaction of Radiation With Matter"; "Pulse Height Spectrometer Systems"; "Calibration, Window Settings, and Stability of Nuclear Medicine Spectrometer Systems"; "Practical Factors in the Use of Scanners and Camera"; "Radiopharmacology—Mechanisms of Localization," as well as discussions on the lung, brain, kidney, heart, thyroid, liver and spleen. These sessions will be of particular interest to radiologists and radio therapists and others interested in nuclear medicine.

The second workshop on "Advanced Breast Cancer" is to be held on March 8 at St. Joseph's Hospital. Dr. Neil Perkinson of Atlanta is the Program Coordinator.

Members of the faculty will include Alfred A. Fraccia of Memorial Sloan Kettering Cancer Center; Lillian Fuller, M.D., of M. D. Anderson Hospital and Tumor Institute; and Robert Mabon, M.D., of Atlanta.

"Chemotherapy of Solid Tumors" is the subject selected for the third workshop scheduled for April 28 and 29 at Callaway Gardens, with Hoke Wammock, M.D., Director of Enoch Callaway Cancer Clinic at LaGrange, and John D. Watson, Jr., M.D., of the Medical Center in Columbus, as Program Coordinators. The faculty for this workshop includes: Albert Segaloff, M.D., Director of Oncological Research, Ochsner Foundation Hospital, New Orleans; Robert O. Johnson, M.D., Professor of Oncology, University of Wisconsin School of Medicine; and Phillip Schein, M.D., Senior Investigator of Solid Tumors, National Cancer Institute.

The workshop on "New Concepts in Treatment of Head and Neck Cancer," to be held June 9 and 10 at the Medical College of Georgia in Augusta, will have as its faculty Drs. Dan P. Sullivan, Harold S. Engler, with Dr. John D. Watson, Jr. of Columbus, Dr. John McLaren of Emory University, Dr. William H. Poole, and others from the Medical College. Herbert E. Brizel, M.D., of the Medical College is serving as Program Coordinator.

In addition, workshops are planned for dieticians, nurses and physicians on "Diet and Cancer" to be held at Memorial Medical Center in Savannah in March. Dr. David E. Tanner of Savannah is Program Coordinator for this workshop. A session for Radiation Therapy Technologists is scheduled at the Medical College of Georgia during the summer of 1972.

To reach nurses who are involved with caring for the cancer patient, three seminars on "Nursing the Breast Cancer Patient" are scheduled for the week of April 10, in Atlanta, Columbus, and Valdosta. Miss Ann Paulen of University Hospital at the University of Wisconsin School of Nursing; Miss Fran Gutowski, R.N., of Memorial Hospital for Cancer and Allied Diseases; Miss Pat Barrett, Chief Technologist, Mammography Department at Emory University will be among those participating on the faculty. Mrs. Rose McGee, Assistant Instructor at Emory University School of Nursing and Chairman of the Nurses' Subcommittee for Professional Education, is the Program Coordinator for this series of seminars.



CARDIAC FLUOROSCOPY— IS IT WORTHWHILE?

ROBERT D. MILLEDGE, M.D., *Atlanta*

ONCE UPON A TIME no "thorough" physical examination was finished until the patient had his chest fluoroscoped. Although the fluoroscope as a diagnostic instrument has been improved many times in the last 20 years, the number of cardiac fluoroscopies done seems to have actually decreased. The question arises: What, if any, is the place of fluoroscopy in the examination of the heart?

Correlation of cardiac catheterization data and contrast angiography with physical and x-ray examination of the heart has taught us that a lot of physiologic information can be extracted from the x-ray film examination of the chest. In fact, plain PA and lateral films provide most of the radiographic information desired about a cardiac patient. Further help is obtained from the cardiac obliques (30° right anterior oblique and 55° left anterior oblique).

In patients with mitral valve disease or left ventricular failure it is possible to infer accurately from the plain chest films the level of pulmonary venous pressure. Educated guesses can be made about pulmonary artery pressure and the status of pulmonary vascular resistance. Pulmonary edema can often be detected on the film before it is apparent clinically. Enlargement of the heart is diagnosable with fair accuracy, but aside from the left atrium (which is easy to evaluate) specific chamber enlargement is not as simple as was once thought.

As a consequence of our increasing ability to interpret them, plain films have more and more replaced fluoroscopy. However, there are still some questions that can only be answered by the fluoroscope.

(1) Are there any calcium deposits in the heart? Although valve calcium can sometimes be seen on the plain film it can never be excluded without fluoroscopy. Aortic valve calcification may be either rheumatic or congenital in origin, but mitral valve leaflet calcification is invariably rheumatic. Often detection of valve calcium will help in diagnosis or therapy (i.e., in a patient with mitral stenosis the presence of valve calcium has a bearing on the type of surgery to be attempted; in mitral regurgitation, the absence of valve calcium may lead one away from the diagnosis of rheumatic disease toward some form of subvalvular mitral insufficiency). Coronary artery calcification indicates coronary atherosclerosis; left atrial calcification is rare but when seen is specific for severe rheumatic scarring. Pericardial and myocardial calcification are usually as well seen on the film as under the fluoroscope.

(2) Fluoroscopy is also the only simple radiologic technique which will outline the intensity and timing of cardiac pulsations. Areas of paradoxical systolic expansion (dyskinesis) or areas of failure of contraction (akinesis) may be seen in some patients after myocardial infarction. Although not all ventricular aneurysms or areas of poorly contracting muscle are visible, probably over half such cases can be found by careful fluoroscopy. The examination definitely is indicated in patients who have suffered myocardial infarction and who are doing poorly.

(3) The third possible use of fluoroscopy is in the detection of pericardial effusion. Layers of radiolucent fat normally accompany the coronary arteries over the epicardium. This fat serves as a marker of the position of the epicardial surface. Separation of epicardial and pericardial surfaces, therefore, implies the presence of pericardial thickening or pericardial effusion. This application is *limited* in the first place because pericardial fatlines are not seen in all patients, and in the second place because a large amount of fluid is required to produce a positive examination. Radioisotope scanning studies are somewhat more rewarding, but the development of echocardiography has for practical purposes rendered fluoroscopy obsolete in the localization of pericardial effusion.

When faced with the decision as to whether to fluoroscope a cardiac patient one should ask oneself what is to be accomplished. If only heart size and hemodynamic state are to be evaluated, plain film examination is adequate. Fluoroscopy should be reserved for those patients who have suspected calcification or contractile abnormalities.

Fluoroscopy should *never* be done as an isolated procedure. The patient fluoroscoped should always have plain film examination of the chest first. It is rarely necessary to do repeated fluoroscopies. One is probably enough and the patient can from that point be followed by plain film examination. Contrary to popular belief, there is probably very little indication for fluoroscopy in infants and children.

One should bear in mind that even since the development of image intensified fluoroscopy, the plain x-ray examination delivers a high resolution image at the cost of relatively little radiation whereas fluoroscopy delivers a lower resolution image at the cost of considerably more radiation exposure.

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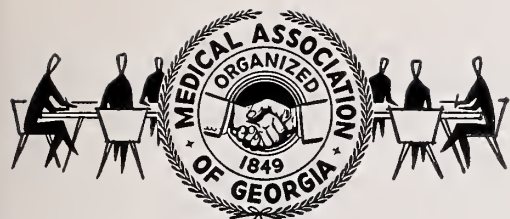
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PERSONALS

Sixth District

L. E. Dickey, Jr. of Macon has been elected president of the Bibb County Medical Society for 1972.

Eighth District

George Mixon of Ocilla was elected president of the Georgia Family Physicians, formerly the Academy of General Practice at a ceremony in Atlanta. Dr. Mixon is the first president elected since the name of the association was changed.

DEATHS

R. T. Anderson, Sr.

Robert T. Anderson, Sr. died in Dublin December 1 at the age of 56.

Dr. Anderson was a native of Jones County and a resident of Dublin for 21 years.

He was a graduate of the University of Georgia and Medical College of Georgia and a World War II veteran.

A member of the First Baptist Church, Dublin Rotary Club and Dublin Elks Lodge, Dr. Anderson was also a Mason and a Shriner.

He is survived by his widow, the former Jane Woodhouse of Dublin; a son, Robert T. Anderson, Jr., M.D.; a daughter, Mary Linda Anderson and two grandchildren.

Frank Norman Gibson, Sr.

Frank Norman Gibson died in Augusta November 20. He was 60.

Dr. Gibson was a graduate of Emory University and received his M.D. from the Emory University School of Medicine. He was a member of Pi Rho Sigma medical fraternity.

A lifelong resident of Thompson, he served as physician in that community for 35 years. He was a former chairman of the McDuffie County Board of Education; trustee and chairman of the Board of the First United Methodist Church of Thompson and chairman of the Board of the White Oak Campgrounds.

Dr. Gibson was the first chief of staff at the McDuffie County Hospital and the 10th District director of the Georgia School Board Association.

Survivors include his wife, Maree Perryman Gibson; two daughters, Mrs. Glenn Yarborough of Fairfax, Va. and Penelope Anne Gibson of Thompson; a son, Frank Norman Gibson, Jr. of Thompson; two sisters and two grandchildren.

THE MONTH IN WASHINGTON

With the exception of House-Senate conference resolution of legislation designed to step up the nation's efforts to find a cure for cancer, the 92nd Congress' activity in the area of health legislation in this session has probably ended.

Senate consideration of the Social Security Amendments (Medicare and Medicaid changes) has been postponed until after the first of the New Year and the House Ways and Means Committee hearings on national health insurance have come to a halt after six grueling weeks and executive sessions will not be scheduled until early 1972.

The House approved 350-5 an expanded \$1.6 billion cancer research program within the National Institutes of Health. The bill differs from a Senate measure which provided that the head of the National Cancer Institute report directly to the White House, by-passing the NIH director. Under the House bill, the Cancer Institute head would be elevated to Associate Director of NIH and the cancer budget would be handled separately by the President's Office of Budget and Management. A House-Senate conference must now determine how to reconcile the important organizational differences in the measures.

The Senate's reluctance to come to grips with the Social Security Amendments of 1971—unfinished business in the last session of the previous Congress—has been attributed to wide disagreement among members as to how to proceed with that portion of the proposed legislation that would establish a new family assistance welfare plan.

On the positive side, however, with respect to the 92nd Congress' attention to health matters is its success with legislation designed to sharply increase the training of physicians, nurses, and other medical personnel.

On signing this legislation, President Nixon called on Congress to appropriate \$350.2 million in additional funds to pay for the program for the rest of the fiscal year that runs through June 30, 1972.

The measure provides grants to medical schools and nursing schools to help finance additional construction and to encourage the enrollment of additional students. It also provides loans and grants directly to medical and nursing school students.

Dr. Merlin K. DuVal, assistant HEW Secretary for Health and Scientific Affairs, said the nation faces a shortage of 50,000 physicians and as many as 200,000 nurses by the end of this decade unless action is taken.

DuVal said the legislation could increase by about 1,200 first-year enrollment of physician candidates in medical schools next year, a 10 per cent increase in the first-year places.

DuVal predicted that if HEW law is adequately funded each year it could eliminate the shortage of physicians by 1980. He said he was unable to make a similar prediction concerning the nursing shortage.

AMA Testimony

The American Medical Association's testimony before the House Ways and Means Committee hearings

on national health insurance attracted for one of the few times during the marathon sessions most of the Committee members, though Chairman Wilbur Mills was away on the campaign trail.

The AMA urged adoption of its national health insurance proposal—Medicredit—as a program that “can be put into operation now.”

The AMA proposal, which offers both basic and catastrophic coverage for all Americans not covered by Medicare, was set forth in testimony before the House Ways and Means Committee by Dr. Max H. Parrott, Chairman of the AMA Board of Trustees, and Dr. Russell B. Roth, Speaker of the AMA House of Delegates.

“I do not want to suggest to this Committee that our present system of health care is perfect. It is not. It needs modification and change. And it will serve people better with the kind of government supported health insurance we propose in our Medicredit bill,” Dr. Parrott told the committee.

“It (Medicredit) avoids the mistake inherent in proposals such as H.R. 22 (the Kennedy-Labor bill), which would lock medicine into a rigid, monolithic, no choice, bureaucratic system before there is any real evidence that it would make things better,” he said.

In contrast to H.R. 22, Dr. Roth stated, Medicredit builds upon outstanding accomplishments of American medicine “which has shown a capability of being the best in the world.”

“And it can be put into operation now. It has no dependence on untried theory or dubious economics. It does not require an unreasonable expenditure of federal dollars and it does not jeopardize the funding of other vitally necessary programs to improve the nation's health. It places emphasis on greater financial support for persons needing this assistance. It does not create an unreasonable, unrealistic and burdensome administrative bureaucracy,” Dr. Roth added.

The AMA Medicredit proposal, whose 160 sponsors in Congress are the most for any national health insurance proposal, would provide both basic and catastrophic coverage for all Americans under age 65. (Medicare would continue for all those over 65.) It is based on a system of tax credits with the government paying the cost for those who have little or no income. The government would also pay the premiums on the catastrophic coverage for all citizens. (The AMA estimates Medicredit would cost about \$14 billion a year. H.R. 22 would cost at least \$60 billion a year in new tax money, according to a recent study by the Department of Health, Education and Welfare.)

Under its basic coverage, Medicredit provides comprehensive benefits in respect to hospital inpatient and outpatient services, as well as full physician services. Its catastrophic coverage includes full hospitalization and additional extended care, with a continuation of outpatient services and full physician services.

“It puts these benefits within the reach of all Americans under age 65 as a prepaid insurance package,” Dr. Roth told the committee. “The benefits are uniform for all citizens under the program. For those with little or no income the cost would be borne by the federal gov-

ernment from general revenues. For those with a capability to pay part of the costs, the program is realistically geared to encourage them to do so. The motivation for participation would, we believe, be especially strong because of our incorporation of tax credits."

Quality of Care

Dr. Parrott, in his testimony, drew the attention of the committee to many achievements in American medicine:

"Those who criticize our system of medicine imply that it is static and must be replaced. Let me call your attention to some of the salient accomplishments of our pluralistic medical system. Accomplishments that are obscured in the radical chic, by a disaster lobby which stridently proclaims a need for revolutionary change.

"Probably our highest achievement is in the quality of medical care in this country. The world standard of medicine is here in this country. American medical schools produce men and women with the best medical education there is. Our technology is unsurpassed. The ranks of allied health manpower continue to grow in terms of both size and sophisticated training."

Dr. Parrott cited the 25 per cent drop in the nation's infant mortality rate in the last decade and the steady growth of life expectancy in the U.S. as evidence "that American medicine—our pluralistic, evolving, pragmatic system—is changing things for the better, that we are making progress."

American medical schools, Dr. Parrott noted, have increased from 89 in 1967 to 108 this year and first-year enrollment has grown from 9,000 to 12,000 students. The number of new physicians each year exceeds 8,000 due in part to "an almost revolutionary telescoping of the traditional medical education." This means, Dr. Parrott said, that the physician population is growing at a rate "more than double" the general population rate.

Organized medicine has also undertaken initiatives to bring medical costs under control, Dr. Parrott told the committee. This is being accomplished mainly through medical society foundations, based on the concept of peer review, which screen hospital admissions and review medical procedures.

"On balance, we have a medical system with impressive accomplishments, a system that is flexible and innovative, a system responsive to the need for change and improvement. In whatever action this committee chooses to take the American Medical Association strongly urges that you build on the very real strength that now exists," Dr. Parrott concluded.

Policy Statement

The American Hospital Association told the House Ways and Means Committee hearings on national health insurance that its *Policy Statement on the Provision of Health Services* provides a direction for national health policy and serves as the basis upon which the Committee can frame goals and programs for the nation's health care.

Jack A. L. Hahn, the AHA's president, told the committee that once goals and priorities have been set, "what needs to be done is to embark immediately on a rationally-staged program within an overall frame-

work of established goals and objectives. Government must take the lead in providing the framework for required changes."

Later in his testimony Hahn said:

"The AHA program has been drafted as a legislative proposal, however, the initial draft is being restudied and revised by the Association. The bill-drafting process showed that simple and readily attainable solutions to complex problems do not exist." Hahn added that the Association had not come with a legislative proposal for consideration by the Committee, but with "recommendations that can be taken now and that can serve as building blocks for the attainment of much broader goals for the system."

Kennedy Committee

Elsewhere on Capitol Hill, the AMA told the Senate Health Subcommittee headed by Senator Edward Kennedy that is now exploring the feasibility of Health Maintenance Organizations that "the concept of the HMO has not yet been tested."

"Our strong recommendation is that we find out whether economics can be achieved before such a major commitment is made," declared John R. Kernodle, M.D., vice chairman of the AMA Board of Trustees.

Stressing that the AMA supports and encourages further experimentation with HMO's, Dr. Kernodle said "HMO's are just one form of health care delivery and no one knows at this time just what impact they will have or how successful they will be in universal application."

With reference to the Nixon Administration's announced goal to make HMO's available to 90 per cent of the population within a decade, Dr. Kernodle said:

"To us (AMA), this is an open-ended commitment. Because of the many unknown factors regarding HMO's we feel it is a rather dangerous blank check for the Congress to issue. For any time you are talking about a program that will affect 90 per cent of the people, you are, in fact, inaugurating a new medical system. It would seem to be the better part of wisdom to be certain of all the facts and cognizant of all pitfalls before embarking on such a course."

Clinton S. McGill, M.D., vice chairman of the AMA Committee on Private Practice, told the subcommittee that less than 4 per cent of the population—generally only highly selective parts of the population—is served by prepaid group practices. "There is little experience with high-risk segments of the population. This, in our opinion, constitutes too narrow a base upon which to construct a new universal system."

Cost Control

President Nixon has appointed a 21-member Committee on the Health Services Industry to oversee inflation in health care costs as part of the Phase 2 economic program. Chairman of the advisory group is Mrs. William C. Dunn, Commissioner of the Department of Consumer Protection for Connecticut.

The Administration intends to cover physicians' services as well as those of all other providers of services in the cost control effort, but the manner in which this will be carried out has not yet been established.

While the government obviously can control to some extent payments in federal programs such as Medicare,



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especially for hospitals, regulating physicians' fees in the private sector is something else again. Apparently, a major thrust of the Phase 2 program as it affects physicians will be to urge voluntary compliance.

The Administration's aim is to keep charges from rising to a point where the unit profit is higher than it was in the past. Fee rises stemming from higher costs of doing business will be okay as will a certain percentage to take into account general rises in the cost of living.

The lack of a penalty-backed policing role by the government—at this date anyway—might seem to make the federal program toothless. But Administration officials are confident that public concern and public and peer pressures will make it difficult for individual physicians to hike fees substantially. Furthermore, the Administration is certain that most physicians are willing to cooperate.

Four physicians are on the panel, which also includes representatives of state and local government, consumers, hospitals, related health occupations and industries and the health insurance companies.

Physician members are: William Lotterhos, M.D., President of the American Academy of General Practice and former chairman of the AMA's section on General Practice; James Haviland, M.D., former acting dean of the University of Washington School of Medicine; Earl Brian, M.D., Director of the California Department of Health Care Services; and James Cowan, M.D., Commissioner of Health for the state of New Jersey.

C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association and former General Counsel for the AMA, is also a committee member.

The decision of HEW to kill the Public Health Service's commissioned corps is sure to fan congressional interest in a separate department of health.

HEW Secretary Elliot Richardson said he was adopting a special advisory commission's recommendation of last summer that the corps—composed of 5,500 physicians, dentists, engineers, nurses, pharmacists, veterinarians—be phased out and replaced with a civilian system.

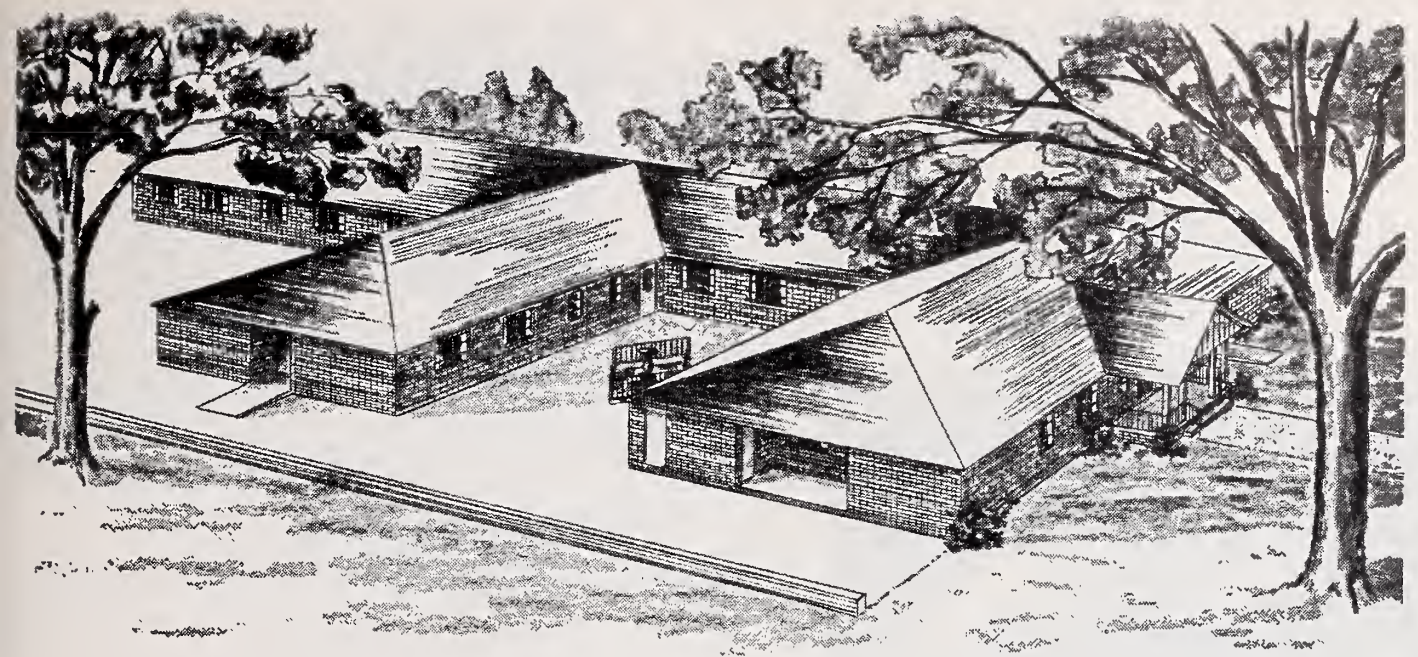
While this would solve a serious internal personnel problem at HEW, the move does nothing to further Richardson's relations with Congress which has had a soft spot for the PHS Corps for many years.

Until recent years, the corps functioned as a semi-autonomous unit at HEW, with the PHS Surgeon General reporting directly to Congress, thus to some extent bypassing higher authorities at HEW. A close liaison with Congress was built up and still lingers on, hence the outcry when the Administration recently moved to close down PHS hospitals.

The reorganization of HEW carried out under HEW Secretary John Gardner firmly placed the secretary and assistant secretaries in control of the agency's health programs and diluted the powers of the Surgeon General to the extent that they are now difficult to define.

However, memories of the old days when Congress was able to call the shots at PHS remain strong and are one reason why such influential men as Rep. Paul Rogers (D.Fla.) are set on establishing a separate, cabinet-level department of health. The reasoning is that only this would give Congress the power it seeks over how the federal government administers its huge health empire.

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Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not been thoroughly investigated. Sulfonamides will not eradicate or prevent sequelae to group A streptococcal infections, *i.e.*, rheumatism, fever, glomerulonephritis. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; early clinical signs such as sore throat, fever, pallor, purpura or jaundice may indicate serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination are recommended frequently during sulfonamide therapy. Clinical data are insufficient to support prolonged or recurrent therapy in chronic renal diseases in children under 6 years.

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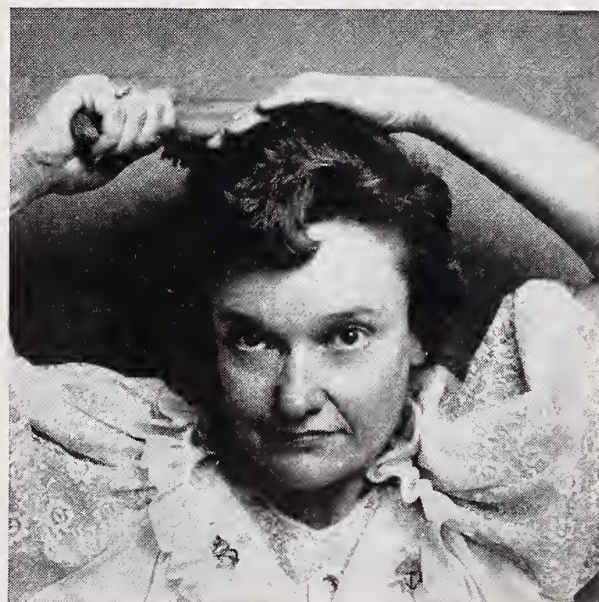
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Adults—2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection. *Children*—0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, followed by 0.25 Gm/20 lbs *b.i.d.* Maximum dose for children should not exceed 75 mg/kg/24 hrs.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

Saturday, December 11, 1971

Finance: Voted to recommend to the Council the following appropriations: \$400 for a mailing in support of the candidacy of J. Frank Walker, M.D., for Speaker of the AMA House of Delegates; \$1,000 for the purchase of office equipment; and \$5,000 to the Legislative Committee for a public relations campaign. Also adopted policy on expense reimbursements stating that expenses for AMA delegates, alternates and officers are to be reimbursed up to the \$50 per diem plus first class travel. This policy was then extended to apply to all members authorized to travel in the name of the MAG.

Awards: Voted to change the name of the "GP of the Year" award to the "Family Physician of the Year" award to conform to the new name of the Georgia Academy of Family Physicians.

Podiatry: Learned of the hearing to be conducted by the Insurance Commissioner regarding payment for

the services of podiatrists and determined that MAG should be represented at that hearing.

Mental Health: Adopted recommendations of the Committee on Mental Health regarding resolutions of the Atlanta and Georgia Associations for Retarded Children, the Governor's Study Commission on Alcohol, Labeling of Drugs, and Amphetamine and Metamphetamine prescriptions. The Committee on Mental Health also stated its opposition to the separation of the Department of Mental Health from the Department of Health as proposed in the Governor's Reorganization Plan.

Headquarters Building Expansion: Authorized the Headquarters Building Expansion Committee to proceed with the plans for enlarging the Headquarters as directed by the House of Delegates in May, 1971.

Next Meeting: 10:00 a.m., January 16, 1972, MAG Headquarters.

HIGHLIGHTS OF COUNCIL

Saturday, December 11, 1971

Finance: Adopted financial recommendations of Executive Committee: \$400—AMA officer campaign; \$1,000—Headquarters office equipment; \$5,000—Legislative Committee public relations campaign; \$1,811.85—increased taxes.

Physicians' Assistants: Voted to support legislation certifying physicians hiring of physicians' assistants, and defining them.

Appointments: Approved Neil T. Boggess, M.D., serving in the place of David Wells, M.D., representing the Seventh District on the Board of the Georgia Medical Care Foundation, with the concurrence of that Board.

Insurance: Approved for statewide promotion a Blue Cross-Blue Shield Plan for MAG members as recommended by the Committee on Insurance and Economics, based on a review of the schedule of allowances by the Foundation Board.

Constitution and Bylaws: Approved the Constitution and Bylaws of the Rabun County Medical Society as recommended by the MAG Committee on Constitu-

tion and Bylaws. Also instructed the Committee on Constitution and Bylaws to develop language which would make MAG Past Presidents Honorary Councilors, and which would change the name of the Council to Board of Trustees or Board of Directors.

Osteopaths: Voted to instruct the Committee on Constitution and Bylaws to resubmit to the MAG House of Delegates in 1972, language which would allow Doctors of Osteopathy to become MAG members.

Abortions: Agreed to support the recommendation of the Committee on Maternal and Infant Welfare that proposed legislation on abortions include a limit on the gestation period of 20 weeks.

Governor's Reorganization: Council confirmed the position adopted by the Executive Committee supporting the present State Board of Health structure and opposing the separation of the Department of Mental Health from the Department of Health. Council determined that an active public relations campaign should be undertaken by the Legislative Committee.

Next Meeting: March 11-12, 1972, Holiday Inn, Callaway Gardens.



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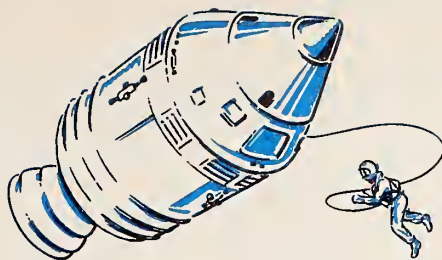
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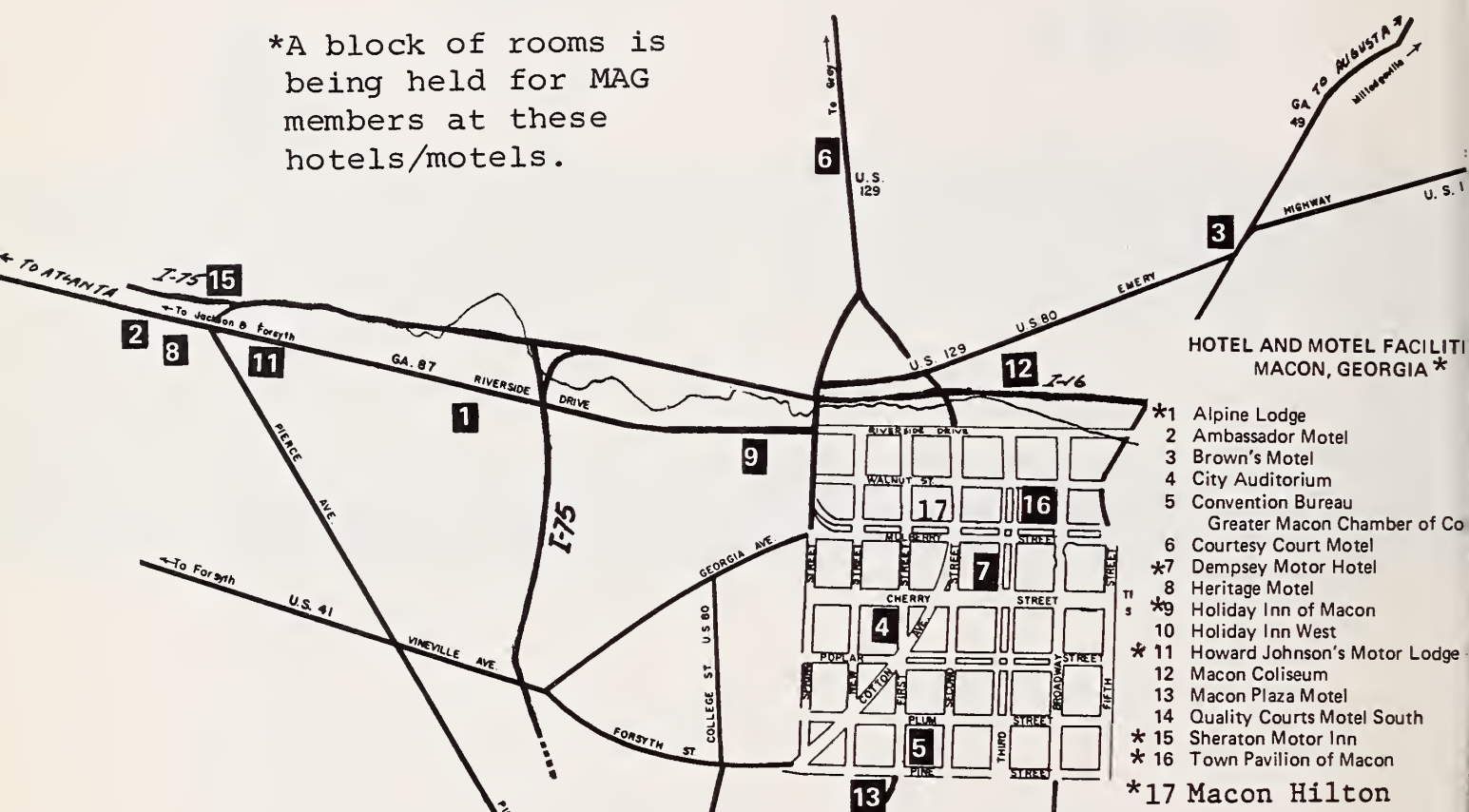
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THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 11, 1972

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 12, 1972

- 9:00 a.m.—First General Session
First Session, House of Delegates
Featured Speaker: "Government Controlled Medical Care"
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Venereal Disease,"
Systems—Past, Present and Future"

6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 13, 1972

- 9:00 a.m.—Reference Committee Meetings
- 10:00 a.m.—Auxiliary General Meetings
- 2:00 p.m.—General Meeting—"Venereal Diseases,"
"Sex in Schools" and "Dynamics of Violence"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 14, 1972

- 7:00 a.m.—Prayer Breakfast
- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia

Annual Session

May 11-14, 1972—Macon, Georgia
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1. Please complete this form and mail to: Reservation Department
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Macon, Georgia (Proper Zip Code)
2. Special reservation forms will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
3. Assignment of rooms will be made in order of receipt of reservation. If possible confirmation will be in accordance with preference indicated; if not, best substitute will be made.
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EMCRO: A Peer Review Mechanism

THE CONCEPT OF peer review—practicing physicians evaluating the quality of medical care—is not a new one to the Medical Association of Georgia or to its component societies. However, in July of 1971 this concept and its application in Georgia was furthered by the award to the Medical Association of Georgia of a federal grant for \$50,000. The goal of this grant by the National Center for Health Services Research and Development is the development of methods of objective medical care review so as to maintain or improve quality of care. The grant creates a Georgia Experimental Medical Care Review Organization (EMCRO) for this purpose. The EMCRO is a project of the Medical Association of Georgia.

Our grant is for development, not operations, and so we have the luxury of time to plan our approach in detail before actually receiving claims or records to review—from whatever source. Our plans must cover the entire range of physician-generated services—from office, emergency room, hospital, nursing home, to home care. Necessity, appropriateness, and quality of care in each of these settings will be examined. The population to be considered by the EMCRO consists of all Georgia residents—whether covered by Medicaid, Medicare, private insurance carriers, or other means. However, at this point, the sources of review data are not critical; the development of mechanisms by which to evaluate this data is the immediate goal.

Any objective means of evaluation requires criteria that can be fairly and consistently applied. In the medical field, these criteria should be developed by practicing physicians. To that end, the EMCRO has requested that criteria for tonsillectomy and adenoidectomy, hysterectomy, cholecystectomy, and pneumonia be developed by the appropriate specialty societies in the state. Criteria Development Committees composed of four or five physicians who treat for the given diagnosis or perform the given procedure are being established by the specialty societies to accomplish this task. Current plans call for the development during the next six months of criteria for four additional procedures (dilation and curettage, appendectomy, repair of umbilical hernia, and surgery for inguinal hernia) and six additional diagnoses (urinary tract infections, chronic heart disease, gastroenteritis, acute myocardial infarction, bronchitis, and diabetes mellitus). It is anticipated that all specialty societies will be requested to develop such criteria in the future. (See Criteria Format.)

During our experimental stage, we envision a sample of interested hospitals as one source of review data to which we will apply these criteria; the hospital staff may consider participation in such a study a part of their continuing program of self-evaluation.

CRITERIA FORMAT

I. Diagnosis or Procedures

A. Outpatient

1. Symptoms
2. Physical findings
3. Laboratory—x-rays
4. Plan of treatment—services, therapies and medications (with frequency)
5. Basis for continuation of plan of treatment
6. End result of treatment

B. Inpatient

1. Indications for admission
2. Hospital services usually provided

3. Hospital services consistent with diagnosis
 - a. Laboratory
 - b. Roentgenology
 - c. Special procedures
4. Probable length of stay
 - a. Preoperative days
 - b. Postoperative days
5. Contingencies that may extend length of stay
6. Indications for discharge
7. Outpatient plan of follow-up treatment
8. End results of treatment

It may also be possible for the EMCRO to utilize the problem-oriented record as a means of assessing quality of care. This application is being explored in part because: (1) a problem-oriented record lends itself so readily to interpretation by others (it is an efficient means of communication) and (2) it promotes quality care by requiring that the physician record the logic of his mode of treatment. Physicians participating in the experimental phase would be asked to prepare problem-oriented records on patients with diagnoses for when criteria had been developed. Such an application of criteria would serve a twofold purpose: (1) to test the problem-oriented record as a data source, and (2) to test the validity of the criteria.

The EMCRO is currently meeting with representatives of the Georgia Nursing Home Association to develop a system of centralized utilization review for nursing homes. Such a system would periodically re-evaluate all nursing home patients to determine if they are receiving the appropriate level of care and to determine if continued stay is medically necessary. In addition, this system would generate certain required reports and statistical data.

A hospital data system is also being considered. Such a system would process abstracted medical data on all discharges and return the data in meaningful summary form (by diagnosis, by service, etc.) to the hospital for use by its medical staff, Utilization Review Committee, etc. It is felt that the provision of this data to the hospital staff would promote staff self-evaluation and thus improvement of quality of care. Here too, required reports and statistical data would be prepared for the hospital. Further, our EMCRO would have available to it a body of medical information to which we could apply our criteria and thus evaluate our own techniques of review.

At the present time, the EMCRO is contracted to provide the entire utilization review function for a Georgia hospital. This is being done on an experimental basis to determine the feasibility of such an approach. Concurrent utilization review functions by way of telecopier transmission from the hospital to EMCRO of a length of stay report initiated when guidelines provided by the EMCRO are exceeded. The EMCRO replies within 24 hours as to whether additional stay appears to be justified. Retrospective utilization review functions by way of EMCRO review of the entire patient record for every inpatient discharged. Determinations as to medical necessity and medical appropriateness of services are made, and the hospital notified as to the results of each review.

EMCRO experiments such as these are undertaken to strengthen and further the concept of peer review by making available to the practicing physician involved in the review process the tools and methodologies by which he can accomplish his task—assessing and improving the quality of medical care.

Peer Review

THE PRIMARY PURPOSE of our peer review is to provide for the people of Georgia medical care of the highest quality, at a reasonable cost, with the efficient use of our medical facilities.

Voluntary peer review has existed since physicians first compared the results of their medical treatment. In recent years the monetary expenditures for health care have multiplied rapidly. Private health insurance benefits have expanded. Federal programs, notably Medicare and Medicaid, have been enacted. The patients, or consumers, have been educated to expect medical care of high quality. These and similar changes indicate that physicians should provide assurances that their services are professionally competent, that their charges are reasonable, and that the medical facilities are utilized efficiently.

It is desirable that the evaluation of the medical care be made by those who are the most capable, by the physicians themselves. The evaluation is most accurate when it is done by physicians of similar skill and practicing in a similar location, by the peers, of the physician whose medical treatment is under consideration. In other words, peer review indicates an evaluation made by one's equals.

The concept of peer review has been endorsed by virtually all of the component societies of organized medicine. The alternative to peer review is unpleasant. Our federal programs are prepared to establish their own mechanisms for reviewing the medical care of physicians, if the physicians are unwilling or unable to do so themselves effectively. New health care proposals in Congress are quite willing to omit physicians entirely from their review procedures if the doctors are reluctant to provide a satisfactory review. Unless doctors are willing to perform responsible peer review, we can expect our various health care programs to establish their own system for evaluating the quality and costs of our services. It is to be expected that their review will be done by clerical personnel, according to the standards of care which they establish, and by the mechanism most convenient to them.

The physicians in Georgia have had effective peer review for many years. The success of its program is the result of the diligence and effectiveness of our 14 local review committees. The review of medical care can be done most accurately by those who are on the local scene. Our most sincere appreciation is expressed to those who serve in this capacity. The same appreciation should be expressed to those who have been selected by our specialty societies to serve on our state Medical Review and Negotiating Committee.

The Executive Committee of the Medical Association of Georgia has adopted a Policy Manual for Peer Review in Georgia. The manual outlines the mechanism to be followed for the review of claims. Procedures are described for use by the individuals, carriers, or committees who may request a review or an appeal of decisions regarding the physician's charges, quality of care provided, or proper utilization by the physician or by the patient of services.

The educational value of peer review is one of its major benefits. The review of medical care can be expected to identify the medical conditions which may not be receiving competent care. Appropriate educational programs can be established to correct these problems.

It is timely to call to your attention a recent ruling by the Supreme Court of Michigan. That court recently held that a medical specialist's standards of care must meet national norms, not merely those standards customarily expected in the geographic area in which he practices. The court states that his care should be that of a reasonable specialist practicing medicine in the light of present-day scientific knowledge, geographical conditions or circumstances notwithstanding. It is well for all specialists to bear in mind the significance of this ruling. The evaluation by our review committees regarding the quality of the care provided by our specialists should also take this ruling into consideration.

John R. McCain, M.D.

COUNTY SOCIETY OFFICERS' CONFERENCE SCHEDULED

The 14th Annual County Society Officers' Conference will be held February 19-20, 1972 at the Sheraton-Biltmore Hotel, Atlanta. This Conference is sponsored by the MAG Committee on Communications' Subcommittee on County Society Officers' Conference under the chairmanship of Dr. J. Watts Lipscomb.

In a continuing direction of the House of Delegates, new members will be invited to participate. These members will be given an over-all look at the Medical Association, what the Association is attempting to accomplish, what services are available to new members and the ways that they can participate in the Association's programs. The benefits of membership in the American Medical Association and the Medical Association of Georgia will be covered as well as information regarding the duties of County Society Officers.

The second portion of the program will be opened by one of the local television weather forecasters with his predictions of things to come. A panel discussion on legislation of concern to MAG will follow with several chairmen of committees discussing their particular

interest in proposed legislation. This is most apropos as the 1972 General Assembly will be in session. It is hoped that the featured speaker for the afternoon will be a Florida Congressman, who will speak on "National Health Insurance and Physician Involvement."

The following day a panel will discuss various aspects of the Georgia Medical Care Foundation, Inc. The "Experimental Medical Care Review Organization," "Project Medicaid Review," "Membership in the Foundation," and the "Future of the Foundation" will be discussed.

On Sunday afternoon and Monday, the MAG Committee on Communications is sponsoring the AMA Speakers and Leadership Seminar immediately following the County Society Officers' Conference. The AMA will be sending staff to give instructions in public speaking and it is hoped that you will attend.

There will be a social hour and musical entertainment by "The Taylor-White Group" for those members attending and their wives on February 19, 1972 at the Sheraton-Biltmore Hotel.

THE AMERICAN FERTILITY SOCIETY MEETING AND CONTINUING EDUCATION PROGRAM

The American Fertility Society announces its Fifth Postgraduate Course and 28th Annual Meeting to be held at The Waldorf-Astoria Hotel in New York City.

The Postgraduate Course will be held on Sunday, February 27, 1972 and will consist of eight seminars to be held at the hotel. In addition, three workshop sessions at area hospitals have been planned.

The Annual Scientific Meeting of the Society will be held February 28, 29 and March 1, 1972. Among the topics on which papers will be presented are: Ovarian Function, The Oviduct, Hypothalamic-Pituitary Function, Immunology, The Male Factor, Population Trends, Fertility Control, Abortion and Sterilization, and Endoscopy.

For additional information and pre-registration forms, please contact: Herbert H. Thomas, M.D., Medical Director, The American Fertility Society, 1801 Ninth Avenue South, Suite 101, Birmingham, Alabama 35205.

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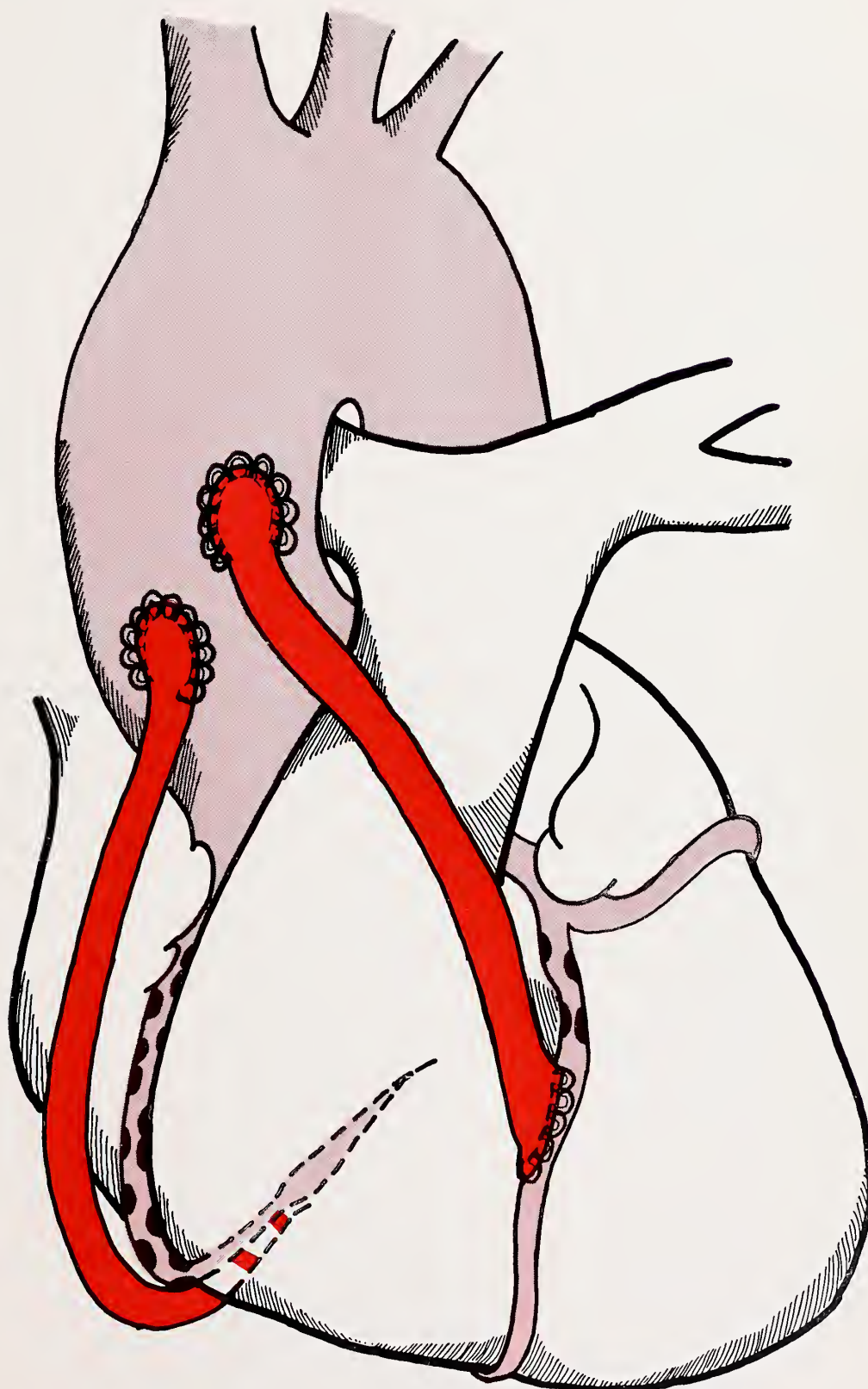
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**Schematic representation of coronary artery
bypass procedure. See page 52.**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Important Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis, a frequently dose-related reaction, may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *allergic reactions:* erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *gastrointestinal reactions:* nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; and *miscellaneous reactions:* drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infection is 4 tablets initially, then 2 tablets morning and evening. If pain persists beyond seven days, causes other than infection should be sought. After relief has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

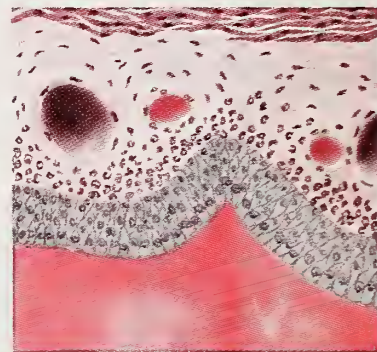
NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

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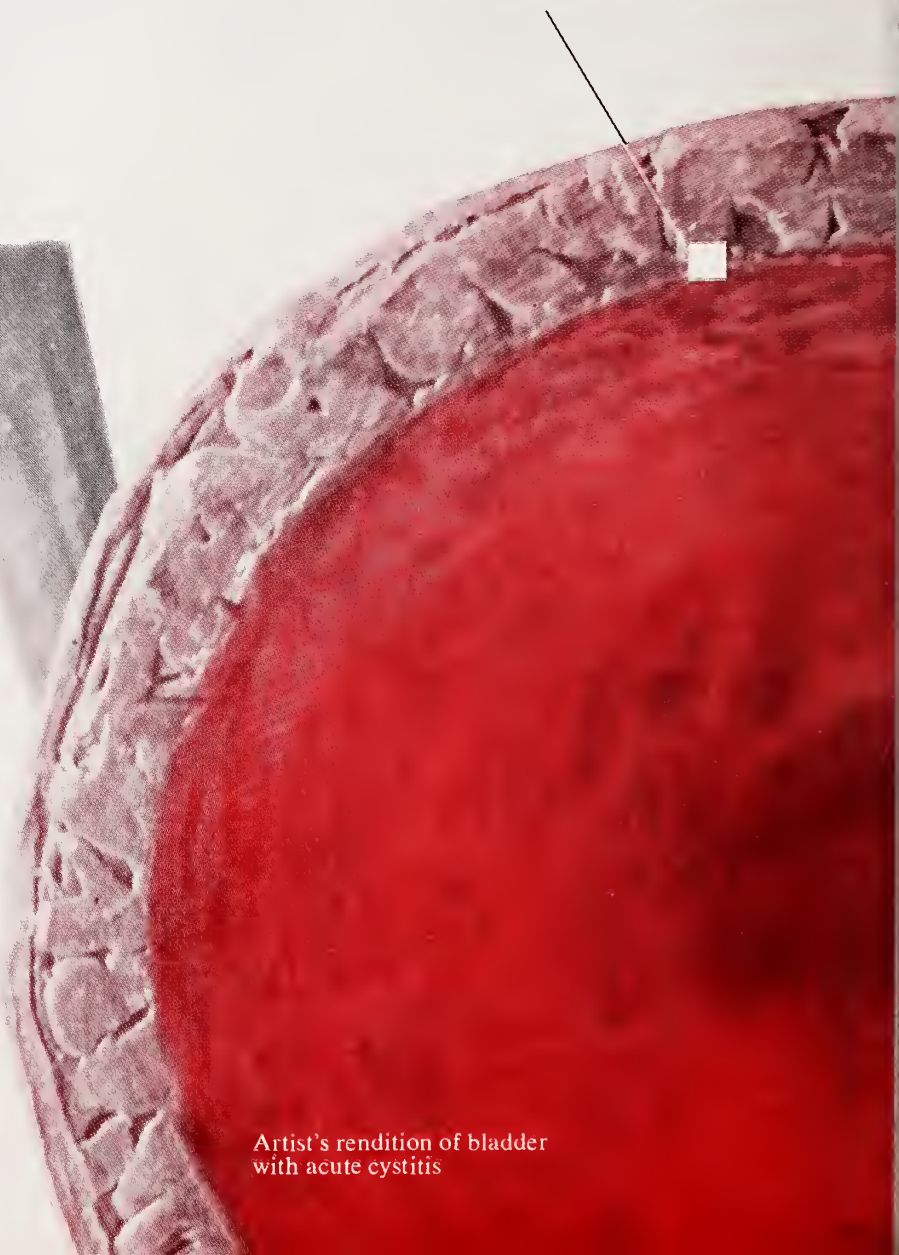
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Artist's rendition of inflamed mucosa of the bladder wall



Artist's rendition of bladder with acute cystitis

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Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenylamidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without pro-

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*See page 57 for the 118th MAG Annual Session
Hotel and Motel Reservation Form*

Contents

Special Article	
MAG POSITION ON GOVERNOR CARTER'S REORGANIZATION PLAN	37
Scientific Articles	
STERILIZATION AT LAPAROSCOPY Earnest M. Curtis, M.D.	39
DOWN'S SYMDROME: EARLY DIAGNOSIS AND CYTOGENETIC FINDINGS Eugene C. Jarrett, M.D., Dave A. Welter, Ph.D. and Dotsie R. Dewberry, B.A.	41
CERVICAL PERCUTANEOUS CORDOTOMY Richard A. Smith, M.D.	44
EXERCISE STRESS TESTING IN THE EVALUATION OF THE CARDIAC PATIENT Avery W. Strickland, M.D. and Martin J. Frank, M.D.	48
Editorials	
CORONARY ATHEROSCLEROSIS: A MEDICAL OR A SURGICAL FUTURE? Mark E. Silverman, M.D.	52
GEORGIA HEART ASSOCIATION ACTIVITIES	54
Features	
Cancer Page	62
Heart Page	63
President's Letter	60
The Association	
Personals	65
Deaths	65

MAG Position on Governor Carter's Reorganization Plan

MAG HAS TAKEN no position on the Governor's total reorganization plan. MAG favors the basic structure and organization of the Board and Department which is charged with the delivery of health care services to the people of Georgia. The vital health care services performed and coordinated by the Board of Health and the Georgia Department of Public Health affect every Georgian, directly or indirectly. Direction of these necessary services should be left in the hands of independent professionals. Quality health care can best be determined, administered and delivered by properly trained and experienced health experts.

This change would not be in the best interest of the people of Georgia. We believe the proposed Department of Human Resources could not be soundly administered, because of the diversity of functions contained in these nine departments which are proposed to be merged. We further believe the proposed Department would not accomplish the desired results of reorganization.

The Board of Health

Governor Carter has made numerous accusations against the State Board of Health. He charges that the Board has been unresponsive to the health needs of Georgians.

The Board of Health is composed of eminently qualified men from the major professional societies in the state, as well as expert representatives from city and county governments. We believe this Board has worked well in the performance of its job and has accomplished much for the people of Georgia.

The Medicaid Program

Governor Carter has charged the Board of Health with poor management of the Medical Assistance Program.

MAG finds the Board has acted efficiently and effectively in the administration of this complex program, often over the objections of and without the cooperation of the Director of the Department of Health.

The Board has taken numerous actions to assure proper controls over the program. Among those taken are:

In 1968, shortly after the Medicaid Program began functioning, the Board initiated work toward a contract between the Department of Health and an outside agency to establish guidelines and review procedures for the Medicaid Program.

In 1969, the Board continued its study of the Medicaid Program and the Chairman requested the Department to strengthen the review procedures. The requested procedures were not effected by the Director, as requested by the Board.

Problems facing the program were compounded by a massive and rapidly increasing list of eligible welfare recipients and spiraling inflation, both of which were beyond the control of the Board of Health.

In January, 1971, the Board demanded that the Department enforce tighter controls.

In February, 1971, the Board directed the Department to undertake an immediate and complete re-investigation of ways to improve cost controls in the program. The Board instructed the Department to work closely with the General Assembly and to include a careful review of fees for service, institutional costs, peer and utilization review.

In May, 1971, the Board authorized a contract with the Georgia Medical Care Foundation to set up a strong guideline, review and control program. This contract was approved in June, 1971.

In August, 1971, the Board approved a contract with the Foundation for the review of physicians' claims which totaled more than \$25,000 for the calendar year 1970.

Effectiveness of the Programs

The effectiveness of the review and controls programs established by the Board is impressive.

An examination of the budget status of the program for the first five months of the present fiscal

REORGANIZATION / MAG

year, ending November 1971, compared with the same period in 1970, reveals:

PERCENTAGE OF BUDGETED FUNDS EXPENDED		
Budget period completed: 41 per cent		
Category	July-Nov. 1971	July-Nov. 1970
Physicians and related services	28.6	81.3
Inpatient hospital	25.1	55.4
Outpatient hospital	37.7	67.1
Nursing home—skilled	36.4	52.5
Nursing home—extended ...	36.7	41.2
Prescribed drugs	26.4	84.5

Significant savings have been accomplished as a result of the review and controls program conducted by the Foundation under contract with the Department of Health at the *insistence* of the Board of Health. Through December 20, 1971, the review process has resulted in the following fund actions:

Physicians' Claims: 3,301 have been reduced, resulting in actual dollar savings of \$86,647.

Nursing Homes Claims: 225 claims have been reduced, resulting in actual dollar savings (based on the three-year "average stay" nursing home occupancy) of \$766,080.

Hospital Claims: 121 claims have been reduced, resulting in actual dollar savings of \$36,474.

Total Dollar Savings for the period of July 1, 1971 through December 20, 1971: \$889,201.

Actions taken by the Foundation's program in 1971 are indicative of the controls which have been instituted and *had been urged* by the Board of Health since 1968.

The program established by the Foundation, in cooperation with the Department of Health, is designed to forward to the Foundation all physicians' claims which exceed parameters established by the Foundation. All of these claims are reviewed by the Foundation. The reviewing process includes three phases: A team, headed by a registered nurse, first examines the claim. If it is felt that the claim is excessive, the claim is then forwarded to a physician consultant for peer review. If the consultant finds the claim to be excessive, the claim is then forwarded to a board of review, composed of physicians, for final action.

The Foundation screened all practicing physicians in Georgia and selected for special review those whose practice patterns appeared unusual. The team now reviews every claim sent into the Health Department by these physicians.

The Foundation reviews every nursing home admission.

The Foundation developed a mechanism and criteria for determining the appropriate level of care for Medicaid patients in nursing homes.

The Foundation reviews all hospital claims based on established criteria.

It should be noted that the Board of Health instructed the Department to forward for review *all claims* which exceed the parameters established by the Foundation. It was estimated that, on the basis of the number of claims submitted to the Health Department for Medicaid payments, the number to be reviewed by the Foundation would be approximately 15,000 per month. However, actual claims reviewed by the Foundation for the period of July 1 through December 30, 1971, totals only 20,784 claims. The Foundation and the Board of Health have continued to urge the Director of the Department of Health to provide the Foundation with a greater number of claims, which would result in greater savings.

Drug Treatment Program

Governor Carter requested the Board to authorize a massive methadone program. He became quite irritated when the Board did not immediately initiate the program.

MAG finds that the Board of Health did, in fact, move forward with this program with positive, mature judgment and action. There was valid reason for the careful, deliberate pace of progress in the program, rather than a headlong rush into a new, untried and potentially dangerous crash program. Methadone is itself a narcotic, a controversial drug. Many experts are reluctant to recommend its use without close personal medical supervision. After careful study, based on their professional knowledge and research into the facts and the anticipated consequences of such a massive program, the Board, in June, 1971, made its decision and moved forward at full speed, to cooperate with the Governor in establishing a safe, workable program.

Mental Health and Prisons

Governor Carter's plan would cast physical and mental health into the same government bureau which administers eight other departments in state government, including the Department of Corrections, and the State Probations Department. Thus, mental health, which has suffered under the stigmatic "prison" image for decades, would be cast back into the same "pit" of association with prisons, pardons and paroles. Experts in mental care in Georgia have spent generations removing from the illness its "prisoner" image. We have taken one step forward. Now, we face two steps backward.

This new method has as its chief advantage a markedly decreased patient morbidity and expense.

Sterilization at Laparoscopy

EARNEST M. CURTIS, M.D., *Atlanta*

STERILIZATION AS a means of contraception has rapidly gained acceptance in the last decade. With it has come an intensified search for better means of interrupting the continuity of the fallopian tubes. This interruption may be accomplished by various combinations of excision, ligation, mechanical occlusion, and coagulation. Tubal coagulation and resection, using the transabdominal laparoscope, has surged to the forefront as a simple, effective and less expensive method of preventing further pregnancy.

Endoscopy is not a new technique but with the recent development of fiberoptic lens systems, excellent and complete visualization of the pelvic structures can safely be performed, as well as certain operative procedures. Most commonly, a rigid, straight lens system with a fairly wide angle of view is combined in a single sheath with glass fibres capable of transmitting cool light from an external source.

Although the procedure may, under certain circumstances, be accomplished under local anesthesia, it is usually best performed under general anesthesia with an endotracheal tube in place. Except for the preparation for the anesthesia itself, only a preoperative enema is required. The patient is placed in a semi-lithotomy position and prepared with an antiseptic solution from the level of the xyphoid down to the pubic area and vagina. The subumbilical margin is grasped with towel clips and a tiny stab wound made in the skin. Using one of several types of needles, the peritoneal cavity is entered and a pneumoperitoneum is produced with either nitrous oxide or, preferably, in our experience, carbon dioxide. The incision is then increased to about 1.5 cm. and the sheath and the trocar are inserted into the peritoneal cavity. The endoscope is placed through the sheath and a panoramic view of the uterus, fallopian tubes and ovaries is obtained. A second, smaller sheath is inserted through the abdominal wall about halfway between the umbilicus and the symphysis pubis, through which a variety of operative instruments may be placed. Using an insulated grasping forcep, each fallopian tube can be elevated and its midportion coagulated for a distance of several centimeters. Thereafter, most authors have preferred to

remove a small segment of fallopian tube using the same instrument. All of this is, of course, accomplished under direction vision. The pneumoperitoneum is allowed to escape through the sheath. No more than one or two skin sutures are required and dressing consists of a Band-Aid.

Most patients have a moderate amount of abdominal discomfort on the day of surgery and many complain of chest or shoulder aching due to the pneumoperitoneum. Rarely is this not controlled with oral analgesics. In our experience, most patients appreciate spending the first postoperative night in the hospital, but it is quite possible to discharge the patient home within four to six hours after surgery. No restriction on activity is imposed following the patient's discharge on the first postoperative day.

The procedure as generally described here has been performed throughout the world on literally hundreds of thousands of patients. In our country, enthusiasm has mounted only within the last few years. The largest series with which I am personally familiar is that done at the Johns Hopkins Hospital in Baltimore. That number exceeds 1,400 patients at the present time.

With tubal coagulation and resection, one would expect at least as good a result as with the usual methods of transabdominal or transvaginal tubal ligation. Reported failure rates have varied from about one in 200 cases to one per 1,000. In the previously mentioned Hopkins series, extending over nearly three years, there has occurred one subsequent intrauterine pregnancy and one ectopic pregnancy.

Complications of the procedure have been quite rare, and have included subcutaneous emphysema, abdominal wall hematomas, traumatic perforation of the intestine, transient bradycardia and an occasional complication of anesthesia. Should severe intrapelvic or abdominal bleeding or small injury occur, laparotomy is necessary.

Sterilization at laparoscopy has been performed by surgeons of every level of training and competence. As one would expect, the more experienced the operator, the less frequently are complications encountered.

STERILIZATION / Curtis

The equipment necessary for this method of sterilization remains expensive and, in its simplest form, costs between \$1,500 and \$2,000.

The most obvious advantage is the brief postoperative recovery period and the short hospitalization. In some centers, the patient is brought into the hospital in the morning, operated upon, and discharged home by afternoon. Contrasted to the hospital stay of four to eight days usually involved with classical techniques of transabdominal sterilization, the domestic and economic advantages to the patient and the Health Insurance carriers are obvious.

The short term of debility places this technique in line with that of vasectomy, and patient acceptance has been overwhelmingly favorable.

Selection of patients for this procedure should be in keeping with existing laws. In the state of Georgia, the patient must be married and a resident of this

state. Obese patients and those with previous lower abdominal surgery should be approached with great caution. Those with active pelvic inflammatory disease or severe tubal distortion must be avoided.

In summary, laparoscopy is an excellent technique for visualization of the pelvic contents. As such, it is a very useful diagnostic tool and may be used for coagulating and resecting the fallopian tubes. This method of sterilization has been widely used, seems to be at least as effective as the standard forms of tubal ligation, and has as its chief advantage a markedly decreased patient morbidity and expense.

275 Carpenter Drive, N.E.

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2. Steptoe, P. C.: A new method of tubal sterilization; *Proceedings of the Fifth World Congress on Fertility and Sterility* (Stockholm) 133:1183, 1967.
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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

Sunday, January 16, 1972

Building Expansion: Learned that steps are being finalized on MAG's Feasibility Study.

EMCRO: Heard that MAG's operational grant for an Experimental Medical Care Review Organization will be submitted on February 1.

Awards: Referred to the Awards Committee the opportunities for nominations for the AMA's Sheen Award and the Georgia Scientists of the Year Award of the Georgia Science and Technology Commission.

Membership Blue Cross-Blue Shield Plan: Instructed Staff to continue negotiations for establishment of this plan.

Foundation: Heard that some of monies owed MAG had been paid with the balance to be remitted by the end of the month. Authorized members of the Foundation Board to submit names of alternates for approval.

GaMPAC: Reviewed candidate selected procedure and noted the value of continued communication between the Executive Committee and the GaMPAC Board.

Laboratory Licensing: Reaffirmed positions regarding license law modifications adopted by the Council in September, 1971.

State Medical Education Board: Suggested that President Mitchell seek replacement in the State Budget of 18 scholarships for medical students, reduced by Governor Carter from the 38 originally appropriated.

Legislation: Decided that the proposed Bill on Physicians' Assistants be written so that physicians' assistants can be hired only by physicians in private practice. Referred to the Committee on Private Practice a proposed bill authorizing non-profit comprehensive health care corporations and directed the Chairman of the Committee on State Legislation to assist in its consideration, along with Drs. Dowda, Haverty, David Wells, and Mitchell.

Podiatry: Heard that no ruling on the payment of Podiatrists by Blue Shield had been rendered by the Insurance Commissioner's office to date.

Next Meeting: February 20, 1972, 11:00 a.m., Sheraton-Biltmore, Atlanta.

*Detailed information is given regarding
the ten cardinal signs which can be
used for diagnosis in the newborn.*

Down's Syndrome: Early Diagnosis and Cytogenetic Findings

EUGENE C. JARRETT, M.D.,* DAVE A. WELTER, Ph.D.,† and
DOTSIE R. DEWBERRY, B.A.,‡ *Gracewood*

WITH THE OVERALL INCIDENCE of one per 600 births, Down's Syndrome, frequently called mongolism or G-trisomy, is one of the most common causes of mental retardation which can be diagnosed clinically. In the older child the diagnosis is accomplished, usually, with relative ease, but at birth diagnosis may be more difficult. Diagnosis at or very near birth, however, is extremely important. Associated with proper diagnosis should be proper counseling so that the parents can have a complete understanding of their infant and his potential. Accomplishing broad counseling such as this requires experience and takes hours of time which many physicians in private practice do not have.

Almost all physicians, especially general practitioners, pediatricians, and obstetricians, will encounter situations requiring counseling regarding children with Down's Syndrome at some times during their careers. Due to the pressures of practice or possibly due to individual biases, this counseling may not be adequate, and more problems for the physician and the family involved will result. There are developing in Georgia, Diagnostic and Counseling Centers such as our own which can provide for the practitioner a readily available means to establish definite diagnosis and to accomplish counseling initially and, if needed, at later dates for the cases that occur.

All Down's Syndrome patients have an extra chromosome in the G group, believed to be a Number 21 chromosome. In 270 cases of Down's Syndrome studied in our laboratory, 253 cases (93%) contained 47 chromosomes. The normal number in

man is 46 chromosomes. In these 253 cases the extra chromosome is an extra 21 (G group) chromosome. In the other 17 cases (7%) there were three different chromosome patterns. Ten of the cases in the smaller group contained the extra 21 chromosome, but it was fused to one of the number 15 (D group) chromosomes, giving a karyotype (chromosome pattern) with only 46 chromosomes. This type of formation is termed a D/G translocation. Six of the remaining 17 cases contained 46 chromosomes, as in the previous ten, but in these cases the extra 21 chromosome is fused or translocated to another 21 chromosome. This is termed a G/G translocation. The remaining case had a certain per cent of cells which contained the normal chromosome karyotype and a certain per cent of the cells which were G-trisomic. This differing of chromosome number among different cells within an individual is termed mosaicism.

Some interesting statistical data about Down's Syndrome that should be kept in mind is that the incidence is about 1:600 viable births. Considering the total number of cases of Down's Syndrome, 78 per cent are born to mothers over the age of 30 years. The majority of those born to mothers over 30 (99%) are G-trisomic, while 9 per cent of the Down's Syndrome born to mothers under 30 years of age are of the translocated type. The chance of a mother between the ages of 15 to 30 years having an infant with Down's Syndrome is about 1:2,000 while after the age of 30 the chances greatly increase up to the age of 45, where the risk is about 1:40. Strong evidence indicates that there is some type of ovarian degeneration with increased age which has strong influence on this change of probability.

More important than the G-trisomy, from the standpoint of genetic counseling, are the translocated

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types of Down's Syndrome. Approximately one-third of the cases of translocated Down's Syndrome come from parents where one is a carrier for this anomaly. The carrier parent would possess a chromosome number of 45, but in essence would have 46 chromosomes because two of the G group chromosomes or a D and a G chromosome would be fused together. One can see how there would be a possibility for the development of an ovum or sperm with the extra G chromosome in a parent with a translocation. As mentioned, 9 per cent of all mongols born to mothers under the age of 30 are of the translocated type as opposed to 1 per cent translocated mongols born to mothers over 30. With the high risk of repeated affected pregnancies in the translocated group, it is imperative that young mothers of these infants have a chromosome study to determine the type of chromosome anomaly that might be present.

There were four families in our studies who had two or more affected children in the same family. There was one family that had three cases and three families with two cases in each. None of these nine children were of the translocated type. In each family the parents were young and the chances of this occurrence should have been high. In another family we found one case of Down's Syndrome and one of Turner's Syndrome (45 chromosomes, missing an X chromosome), and again the parents were young. The etiology of Down's Syndrome occurrence is still unknown, but there is evidence that factors such as radiation, viral diseases, thyroid dysfunction and other external factors may be involved in this aberrant process. It is also felt that there is some type of ovarian degeneration with increasing age that could influence the development of this syndrome. For these reasons it is imperative that we obtain chromosome studies on as many parents as possible who have children with Down's Syndrome. Equally important, we must obtain an accurate clinical history of these parents so that the influence of these factors can be clarified.

Since 1866 when Langdon Down¹ separated the mongoloid children from the general population of mentally retarded, many typical physical features have been described. These features as a general rule are present in the child after six months of age, but diagnosis needs to be accomplished at birth.

Ten cardinal signs of Down's Syndrome in the newborn were established by Hall in 1964.² These findings were determined by the fact that they were usual in the mongoloid child but unusual in other infants. Also, these signs were not different manifestations of the same defects. The signs are: (1) hypotonia, (2) poor Moro reflex, (3) flat facial profile,

(4) oblique palpebral fissures, (5) dysplasia of the ears, (6) excess skin on the neck, (7) simian crease, (8) hyperflexibility of the joints, (9) dysplasia of the pelvis, and (10) dysplasia of the middle phalanx of the fifth finger.

The evaluation of the Moro reflex and muscle tone are routine as part of the examination in the newborn, and abnormalities in these areas should be picked up readily. The facies of the infant with Down's Syndrome tend to be fairly characteristic. The face is often dull in appearance with coarse, insignificant and poorly fashioned features. It tends to be expressionless, and the flatness is due to hypoplasia of the maxilla. Oblique palpebral fissures are findings which are well-known for the older child with Down's Syndrome but are also valuable in the newborn. Dysplasia of the ears is variable, and the concentration should not be on specific abnormalities of the ears but rather whether the ears are definitely normal or not. Generally speaking, the ears in Down's Syndrome are simple lined, smaller, and more rounded with rolling over of the upper helix, and the ear lobes may be very small or, indeed, absent. There is excess skin, especially on the back of the neck, with very loose folds there. Other skin findings are present such as cutis marmorata, but these findings are not uncommon in children without Down's Syndrome.

The simian crease is a single transverse palmar crease which is the least valuable of the ten cardinal signs. This crease can occur in children without Down's Syndrome and is not present in each child with Down's Syndrome. In addition to the single transverse palmar crease, the palms of the hands and toes and feet tend to have more small, nonspecific creases than normal children. The palmar axial triradius is in a distal position in most children with Down's Syndrome, but this is difficult to evaluate without experience and some special equipment. Dysplasia of the pelvis is a very good sign. The iliac index is not well suited in the newborn due to small turnings around the transverse axis producing changes of the acetabular and ilium angles. More important is the outward flaring of the iliac wings. Dysplasia of the middle phalanx of the fifth finger is also a very important sign. This finding is probably rare in adults with Down's Syndrome but is present in the majority of mongoloid infants. Dysplasia can vary from mild changes to a complete absence of this phalanx.

Other physical findings which should be considered both in the newborn period and at later ages involve many systems. Generally speaking, these findings are due to disordered growth of the skeletal system, especially the skull and long bones, but other systems obviously are involved also. The skull is usually

small and tends to be flattened in the anteroposterior aspect resulting in the skull type termed brachycephaly. The orbital areas are smaller than normal, and the previously mentioned oblique palpebral fissures are present. Epicanthal folds are present in most cases. These folds are confined to the inner angle of the eye as opposed to those of the Asian population where the epicanthal fold involves the entire upper lid. The epicanthus in Down's Syndrome tends to disappear after early teenage years. Frequently, cataracts are noted as is a chronic conjunctival irritation.

The tongue frequently protrudes and, if the oral cavity is markedly small, this may be a significant problem. Constant sucking motions on the tongue are thought to be the etiology of the fissuring of the tongue which is a fairly common finding in the older child. Teeth are delayed in eruption and tend to be small and abnormally placed.

The hypotonia which is present in these children results in the quite prominent abdomens. There is, as previously mentioned, dysplasia of the middle phalanx of the fifth finger, and the hands and feet tend to be broad, flat and square. Incurving of the fifth fingers is a common finding, and the space between the first and second toes and fingers is increased with a prominent skin crease in this area on the sole of the foot. The genitalia are poorly developed and secondary sex characteristics are delayed though Down's Syndrome is one of two chromosomal abnormalities in which the female can be fertile. An interesting finding is straight and silky pubic hair.

Cardiac problems are very frequently seen, and these are most commonly in the atrioventricular structures of the heart. The skin is dry and cracks very easily and is quite susceptible to skin infections. Laboratory studies have not indicated any significant endocrine or metabolic abnormalities though problems of these types do occur in Down's Syndrome. The incidence of seizure problems is about the same as is noted in the general population. No characteristic changes have been found in the brain. Minor fissural and gyri changes are noted, and there is a minor reduction in the number of ganglion cells. Some have recorded spotty defective myelin formation also but nothing which is in itself diagnostic. Life-span of children with mongolism who do not have other associated problems is not necessarily shortened if they receive good medical care. Some studies have indicated that as high as 50 per cent of the children die within the first year, but these studies have included children who also had congenital heart disease which is the primary condition associated with early death. Individuals with Down's Syndrome tend to have delayed physical growth until puberty

and then a somewhat accelerated senescence after a brief middle age.

Other conditions which can be associated with early death are anomalies of the intestinal tract with obstructions, most frequently duodenal stenosis. Hernias are not uncommon and tissue repair after surgery is generally poorer than in unaffected children.

Early accurate diagnosis, which should include chromosomal analysis as indicated above, provides a firm base for counseling for the parents of the infant. This counseling should be comprehensive, preparing the parents so that they can look forward to the development of their child. Though the development will be slow, these children generally will be lovable and friendly and usually will be only moderately retarded if exposed to life in a healthy family situation. Some will be severely retarded but some also will be mildly retarded or even borderline normal in intelligence. Their social abilities may cause them to appear less retarded than they actually are. It is a great tragedy for an infant with mild retardation or borderline normal intelligence to be treated as if he were more severely retarded.

Chromosomal analysis is relatively painless, requiring only four drops of blood for the study. This service, as well as all others mentioned, is available at our center as part of routine comprehensive outpatient evaluations. Utilization of these services by physicians assists parents in meeting the needs of their child from a very early age, thereby, preventing problems from developing for them and for their community.

Summary

Chromosomal data is presented on 270 cases of Down's Syndrome studied in our laboratory indicating the three ways in which the syndrome can develop. Probabilities of the syndrome occurring in mothers of different age groups is discussed. Detailed information is given regarding the ten cardinal signs which can be used for diagnosis of Down's Syndrome in the newborn.

The practicing physician is encouraged to take advantage of centers within the state providing specialized services for the mentally retarded. Together the physician and the center team will be able to adequately prepare the family to meet the special needs of their child with Down's Syndrome, thereby preventing problems from developing in the family and community.

Gracewood State School and Hospital

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This procedure extends the benefit of cordotomy to many patients who could not tolerate laminectomy.

Cervical Percutaneous Cordotomy

RICHARD A. SMITH, M.D., *Atlanta*

RELIEF OF INTRACTABLE PAIN continues to present a major challenge to the physician. One of the standard surgical procedures to achieve this has been anterolateral cordotomy, first introduced by Spiller and Martin¹³ in 1912, and further developed as a precise operation by Frazier¹ and Kahn.^{3, 4} In an effort to minimize the morbidity of cordotomy, and to extend its benefits to patients otherwise considered unsuitable for such a major operation, a technique of percutaneous cordotomy has recently been evolved by Mullan,⁶ Rosomoff,^{9, 10} Lin,⁵ and others.^{2, 14} This procedure has aroused considerable interest, and has become the preferred method for relief of certain types of pain in many leading neurosurgical centers.

Rationale

The anterolateral quadrant of the spinal cord contains spinothalamic fibers conducting modalities of pain and temperature from the opposite side of the body to the thalamus, and thence to the cerebral cortex. Section of this quadrant does not sacrifice any other indispensable functions. However, tracts subserving the skeletal muscle system and bowel and

bladder control are in potential jeopardy because of their close proximity. To be not only effective but safe, percutaneous cordotomy must obviously be performed accurately; this requires both radiographic and physiologic guidance.

Technique

The procedure is carried out under local anesthesia. Spinal puncture is performed through a lateral approach between the neural arches of C1 and C2. The anterior surface of the spinal cord may be outlined with air or with Pantopaque® emulsified with spinal fluid; the latter outlines the dentate ligament marking the equator of the spinal cord as well. The tip of the needle is positioned against the lateral surface of the cord, anterior to the dentate ligament (Figs. 1 and 2). At this point, the flow of spinal fluid

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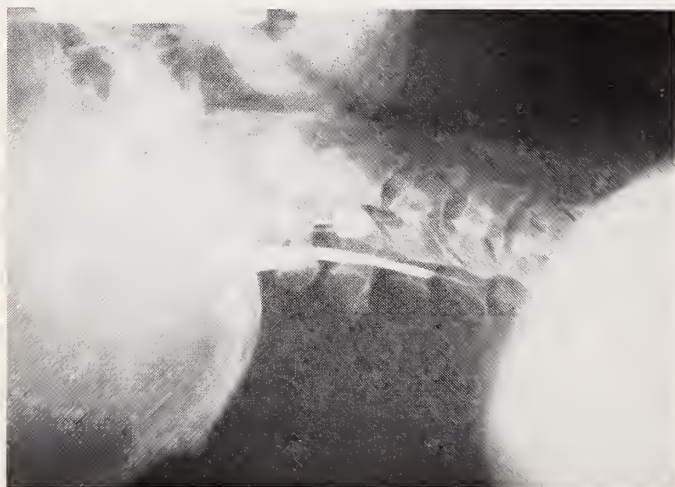


FIGURE 1



FIGURE 2

from the needle may cease. Biplane fluoroscopy with image intensification, in place of conventional radiography, facilitates this stage of the procedure. A fine electrode, insulated except for its tip, is then inserted through the spinal needle into the anterolateral quadrant of the cord (Fig. 3). Electrical stimulation helps to confirm the proper position of the electrode. Contralateral paresthesias indicate satisfactory placement, whereas extremity muscular twitching points to involvement of the more posterior motor pathway. The lesion is made by heating with a radiofrequency current from a suitable generator. Irritation of the second cervical nerve root at this time may cause intense pain, which may be controlled with a combination of epidural and 0.1 cc. intrathecal local anesthetic, intravenous analgesics, or innovar anesthesia if necessary. The lesion is completed in small increments, with careful testing of sensory and motor function after each application of current. A successful lesion may require many trial positionings of the electrode.

Alternatively, an anterior cervical approach can be used in which the needle is passed through an intervertebral disc space. This may, however, be more difficult.

Results

The author has completed 20 cordotomies in 19 patients. Although this is a relatively small series, it is fairly representative of the successes, failures, and complications encountered by others. Sensory levels obtained are shown in Figure 4, and the overall results are summarized in Table 1.

In three cases, the result became more complete 24 hours after cordotomy: in one of these, the level ascended from C5 to include C2; and in the other two, areas of initial sparing (T1-T8, and T12-S5) became analgesic. There were some islands of apparent sparing of pain sensation in the posterior thigh in one patient, and at the midthoracic level in another. Two patients have had some return of pinprick perception after six months, but fortunately with little return of pain.

As in open cordotomy, the best results were obtained in cases of unilateral intractable pain secondary to cancer. Except for the emergence of contralateral pain in two patients, there was no failure to obtain either good or complete relief of pain in this group of nine patients.

The results with pain of nonmalignant origin are less certain, and with increased longevity, late failures are more apt to occur. However, a patient with severe neuralgic pain in the hand, persisting after decompressive laminectomy for cervical spondylosis, has been relieved for 3½ years; analgesia has been maintained below the level of C2. Another patient, with sciatic neuralgia secondary to a gunshot wound of



FIGURE 3

the cauda equina, has been relieved of her sharp pain for three years, although she still has some cramping sensations in the leg. Two patients with sciatic neuropathy secondary to disc disease, not relieved by multiple back operations, have been improved. However, one is troubled with some burning paresthesias in the lower leg; the other continued to have sacral pain necessitating further treatment. One patient with intractable pain from diabetic neuropathy and degenerative hip disease was relieved.

The more severe pain of herpes zoster intercostal neuralgia has been relieved in two patients, but both continued to complain of soreness and hypersensitivity; the result was considered fairly good in one but poor in the other. Another patient with intercostal neuralgia, secondary to a thoracotomy scar, was relieved of sharp pain but continued to complain of a “swollen” feeling and hypersensitivity, and in addition, postcordotomy burning paresthesias in the leg.

A patient with diffuse cramping, aching, and burn pain in the right lower abdomen and leg of obscure origin has not been relieved despite complete analgesia below C2, emphasizing the risk of failure in such cases. Another failure was a case of painful brachial plexus stretch palsy, despite a sensory level to C4; however, this problem was complicated by narcotic addiction and paranoia.

Complications

Complications encountered are listed in Table 2. Horner’s Syndrome occurs so frequently with cervical cordotomy that it may be considered an anticipated result; it was observed in ten patients.

More serious are disturbances of motor control of the ipsilateral arm and leg. Two patients had some permanent weakness of the arm; these complications occurred early in the series and have subsequently been avoided by refinement of the technique. Five patients have had transient weakness of the arm and leg; two patients had transient weakness confined to the arm, and one patient, to the leg. The degree of

Analgesic Levels in 20 Cordotomies

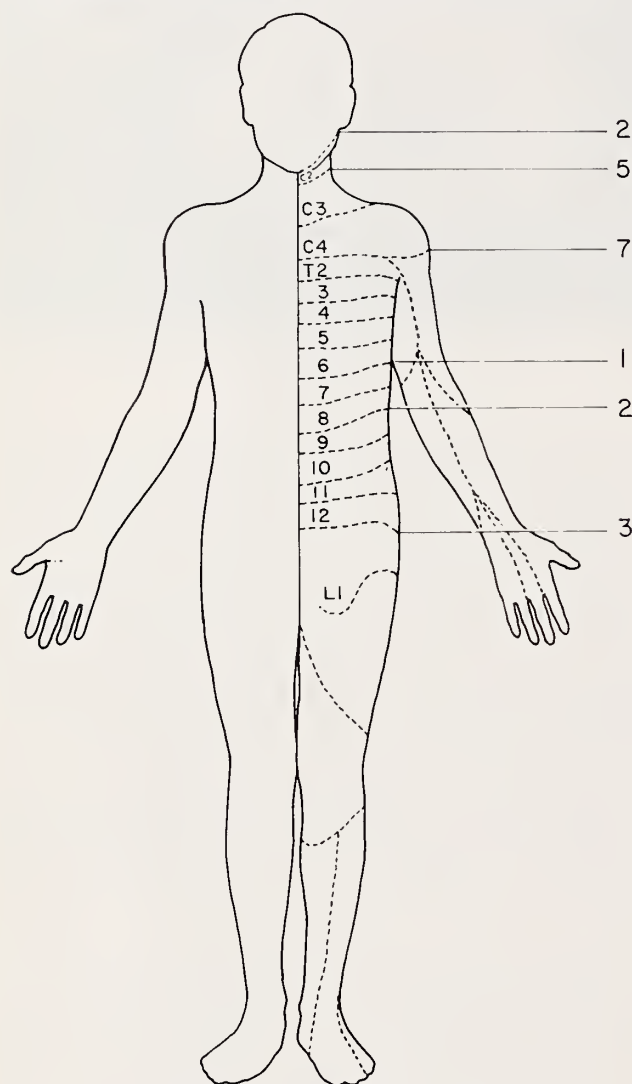


FIGURE 4

weakness has generally been quite mild, recovering within a few days in most, but occasionally lasting several weeks. However, the risk of permanent monoparesis or hemiplegia, albeit small, cannot be discounted.

There has been no permanent disturbance of bladder control in this series. Seven patients had transient urinary retention, which may have been related more to bed confinement and sedation than to a specific effect of the cordotomy.

Postcordotomy burning paresthesias can sometimes be a source of major complaint. This complication occurred in two patients, restricted to the leg. There is no known effective treatment.

There have been three deaths in the immediate postoperative period in this series, an incidence of 15 per cent. One patient died 24 hours after cordotomy from myocardial insufficiency, and another at three weeks from myocardial infarction. Although these patients were very ill with advanced cancer,

their cardiac deaths suggest that the stress of percutaneous cordotomy, while certainly less than open cordotomy, cannot be ignored.

The third patient apparently died of respiratory failure. This is a singular effect of bilateral cervical cordotomy following which respirations may be adequate while the patient is awake, but cease during sleep.^{7, 11} A similar risk of sleep-induced apnea may occur following unilateral cervical cordotomy in the presence of severe respiratory disease,⁷ and was believed to have occurred on the third postoperative night in this patient, with cancer of the lung constricting the trachea.

TABLE 1
RESULTS

Group I: Nine Cancer Patients

A. Complete Relief (5)

1. Left shoulder and arm (Pancoast tumor)
2. Left arm, hip, and groin (Ca. Cervix: Lumbosacral plexus and supraclavicular nodes)
3. Right arm (Ca. Lung)
4. Left hip (Ca. Colon)
5. Right thigh (Ca. Colon: Lumbosacral plexus)

B. Good Results (2) Slight sparing posterior thigh requiring mild oral analgesics

6. Left hip and leg (Ca. Lung: Lumbosacral plexus)
7. Left hip and leg (Ca. Colon: Lumbosacral plexus)

C. Relief of Ipsilateral Pain, Emergence of Contralateral Pain (2)

8. Left hip and shoulder (Ca. Prostate) Right hip pain partially relieved with contralateral anterior cordotomy at C4
9. Abdomen (Ca. Kidney) Contralateral pain controlled with narcotics

Group II: Ten Non-Cancer Patients

A. Relief

1. Neuralgia of hand: 4 years (postoperative cervical spondylosis)
2. Neuralgia of leg: 3½ years (gunshot wound cauda equina)
3. Diabetic neuropathy and degenerative hip disease

B. Partial Relief

4. Sciatic neuropathy, postoperative disc; sacral pain required rhizotomies, dorsal column stimulator
5. Sciatic neuropathy, postoperative disc; persistent burning paresthesias
6. Intercostal herpes zoster; persisting hyperesthesias, fair relief
7. Intercostal herpes zoster; persisting hyperesthesias, poor relief
8. Painful thoracotomy scar; sharp pain relieved, persistent hypersensitivity, postcordotomy burning paresthesias

C. Failure

9. Brachial plexus stretch palsy
10. Cramping, aching, burning abdominal and leg pain of obscure origin

Discussion

The indications for percutaneous cordotomy are in general the same as for open cordotomy: pain of organic origin in the trunk or extremities, intractable to relief with appropriate analgesics. The pain should be sharp, shooting, or toothache in quality; psycho-

TABLE 2
COMPLICATIONS OF PERCUTANEOUS
CORDOTOMY

	Patients
Horner's Syndrome	10
Permanent paresis of arm (early in series)	2
Permanent paresis of leg	0
Transient paresis	
Arm and leg	5
Arm	2
Leg	1
Permanent loss of bladder control	0
Transient urinary retention	7
Postcordotomy burning paresthesias	2
Deaths	3
Myocardial	2
Nocturnal apnea	1

genic, cramping, burning, or other dysesthetic "pain" will not be relieved by this technique. Failure is particularly apt to occur in certain pain syndromes: herpes zoster,⁴ injury to the spinal cord above the cauda equina, avulsion injury of the brachial plexus, spinal arachnoiditis, cramping muscular pain, and burning perianal pain.¹⁵ Furthermore, recession of the postoperative level of analgesia with the passage of time limits the long-term effectiveness of cordotomy to approximately 50 per cent or less,^{12, 16} and underscores the primary usefulness of cordotomy for patients with malignant disease.

The theoretical advantages of percutaneous cordotomy over open operation are several. There is considerably less operative trauma, so that the procedure may be done for patients too ill to tolerate laminectomy, or in whom the life expectancy might not justify it. By careful monitoring, in a cooperative patient, the resulting analgesia may be better, with less risk of complication. Should failure occur, the procedure can be repeated relatively easily.

However, there are some disadvantages. The procedure is not entirely painless. In two apprehensive patients (not included in this series), it had to be terminated before a lesion could be made; open cordotomy under general anesthesia was subsequently successfully accomplished. It is less suitable for bilateral pain, since the risk of respiratory failure with bilateral high cervical lesions dictates that the lesion on at least one side should be made at a lower level, such as by a subsequent anterior approach. In such patients, a single stage, bilateral high dorsal open cordotomy may be preferable. Furthermore, in some patients, the risk of any motor impairment in an upper extremity, or of any loss of pain and temperature sensation in the hand, may be unacceptable, when analgesia below the umbilicus by a thoracic cordotomy would suffice. Finally, there is some evidence that the analgesia of percutaneous cordotomy may not be as lasting as with open cordotomy.⁸ For

these reasons, the author does not agree with those who feel that percutaneous cordotomy has rendered cordotomy by laminectomy obsolete.⁹ Rather, both procedures have certain advantages and disadvantages; the choice depends upon a careful selection of patients, plus the experience of the surgeon, to achieve the best result with the least distress to the patient.

Summary

Percutaneous cordotomy is a new technique in which a lesion is made in the anterior quadrant of the cervical spinal cord by means of a radiofrequency current, carried by an electrode inserted through a spinal puncture needle. It is particularly advantageous for patients suffering from unilateral pain secondary to advanced malignant disease, and extends the benefit of cordotomy to many patients who could not tolerate laminectomy.

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The advantages and limitations of this useful procedure are outlined and discussed.

Exercise Stress Testing In the Evaluation of the Cardiac Patient

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MOST OF THE NECESSARY INFORMATION needed to evaluate the cardiac patient is provided by taking a good medical history, performing a thorough physical examination, and obtaining a resting electrocardiogram and routine chest x-ray. The above standard methods of evaluation are the physician's most important tools. However, there are situations where we can gain important additional information by performing an exercise stress test. These include the confirmation of the diagnosis of coronary insufficiency by demonstrating exertional myocardial ischemia; the objective determination of the functional capacity of the cardiac patient; and the evaluation of medical or surgical therapy by serial testing.

The stress of exercise increases total body oxygen demand which is delivered by an augmented cardiac output. Myocardial oxygen requirements are augmented by the increased heart rate, left ventricular wall tension, and contractility of the exercising heart. The healthy individual can increase his coronary blood flow in response to exercise and thus meet the increasing myocardial oxygen demand. However, coronary vascular disease reduces the ability of the coronary vasculature to increase myocardial oxygen delivery by increasing flow, and at some point the increasing demand cannot be met. The resultant myocardial ischemia is reflected in the electrocardiogram by ischemic ST changes, a sagging or horizontal ST segmental depression.

The first report of recorded ST segment depression and T-wave inversion in patients during attacks of classical angina pectoris was by Feil and Siegal in 1928.⁶ While Master introduced his standardized two-step test in 1929, it was originally used to observe only pulse and blood pressure responses to ex-

ercise.¹¹ It was not until 1941 that he described the ST segment changes resulting from the performance of this test.¹² The Master Test is based on a standard number of trips across a pair of nine-inch steps. The number of trips is varied according to the weight and age of the patient. The test has been criticized for not requiring enough exertion on the part of heavier patients while penalizing the little guy. The problem arises because of the strong positive correlation between total body oxygen requirement, muscle mass and body weight. Moreover, changes in heart rate during stress depend upon the rate of work, not body weight. The two-step test has been the most widely used form of exercise stress testing but in recent years more strenuous methods have been developed. In particular, treadmill testing is increasing in popularity because of its ease of performance and high level of reproducibility. A bicycle ergometer may also be used, but many patients seem to tolerate the treadmill better, particularly if they are not accustomed to riding a bicycle. With treadmill testing, the workload is increased by increasing the speed and uphill grade. Bruce and associates³ have popularized a multistage treadmill test where the patient is exercised to exhaustion, Table 1. In our experience, the average patient with little or no cardiac impairment is able to complete Stage 3, signifying a New York Heart Association Functional Classification I. Sheffield and associates¹⁷ recommend performance of a submaximal test designed to reach 85 or 90 per cent of the predicted heart rate for that age after two and one-half minutes of steady state exercise with the total period of exercise being five minutes. The maximal heart rate at age 20 is approximately 200 beats per minute and decreases by approximately ten beats per minute each decade. Therefore, 85 per cent of the maximal rate is approximately 170 beats per minute at age 20, decreasing by ten beats per minute each decade. In practice, the two systems can be combined so that the Bruce system is employed, but the end point sought is 85 or 90 per cent of the predicted rate.

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A resting 12 lead electrocardiogram should be performed prior to stress testing to help exclude a recent myocardial infarction which is an absolute contraindication to testing. The test is also contraindicated in persons with acute illnesses, exertional syncope, myocarditis, recent pulmonary embolism, serious ventricular arrhythmias, digitalis and quinidine toxicity, and musculoskeletal problems that interfere with walking. The information obtained from testing may be misleading after a significant period of voluntary restriction of physical activity, or prolonged confinement to bed. There is no reason to exclude patients with angina pectoris, ventricular premature beats, or a past history of congestive heart failure. In fact, the test may prove to be of greatest value in evaluating the effects of medical or surgical therapy in this group of patients.

The equipment necessary for testing includes a variable speed and variable grade treadmill, an electrocardiograph, a watch or wall-clock with a sweep second hand, and a sphygmomanometer. While exercise testing has proven to be a reasonably safe procedure even with maximal exertion, it is wise to have a physician as well as a technician present during the procedure. An emergency drug tray should be within reach, and a defibrillator is desirable particularly when exercising patients to exhaustion. Blackburn¹ has determined that the most sensitive monitoring lead is a bipolar lead from the right subclavicular or perimanubrial area to the fifth intercostal space at the left anterior axillary line. The latter location corresponds to V₅ which is the most sensitive of the conventional unipolar leads. The sensitivity of the system can be increased by the addition of other bipolar leads, for example, those with the positive terminal in the position of V₃ or V₇. Attachments of leads is best accomplished through the use of a "stick-on" disposable electrode system (e.g., the cardio-sentinel disposable electrode, Wren-Fogle Electronics Incorporated, Columbia, South Carolina). Most authorities monitor the electrocardiogram continuously during exercise in order to observe for the development of cardiac arrhythmias, ST segment depression, and the obtaining of submaximal or maximal heart rate. However, if an oscilloscopic monitor is not available, the precordial electrocardiogram should be recorded at a frequency of at least once per minute. Continuously direct observation of the patient is always required to look for signs of undue fatigue or cerebral ischemia. Patients subject to exertional hypotension, e.g., those with severe mitral or aortic stenosis or marked cardiac impairment from multiple myocardial infarctions, should be evaluated at intervals by taking the blood pressure. The test should be terminated with the onset of angina, serious arrhythmia or conduction distur-



FIGURE 1

Positive ischemic response to exercise with horizontal depression of the ST segment.

bances, pallor, failure to respond to questioning, or the beginning of staggering. Exercise should also be discontinued if the heart rate achieved significantly exceeds that predicted for maximal exercise capacity. Since treadmill testing requires only the experience gained in the usual method of locomotion, most patients are able to continue until submaximal heart rates are achieved even without physical conditioning.

Interpretation

Exercise may lead to many changes in the electrocardiogram, but only sagging or horizontal depression of the ST segment is correlated with the development of coronary ischemia.^{2, 5, 13} A typical example of a positive response is illustrated in Figure 1. A common finding in the exercising electrocardiogram is false junctional depression due to atrial repolarization, Figure 2(A). This type of tracing is common with rapid heart rates. The points where the PR segment joins the Q-wave must be taken as the baseline in order to avoid misinterpretation of the record. At times one may see true junctional ST depression with an upward ST slope, Figure 2(B). This represents an equivocal response to exercise, but should be considered negative if the ST segment returns to the isoelectric line rapidly (within 0.08 seconds). Only true J point depression with downward ST slope and horizontal ST depression should be considered as a positive (ischemic) response, Figure 2(C) and 2(D). The incidence of myocardial infarction in patients who develop no electrocardiographic change, cardiac arrhythmia, or simple T-wave inversion is less than 5 per cent.¹³ Simple J point depression with an upward sloping ST segment also correlates

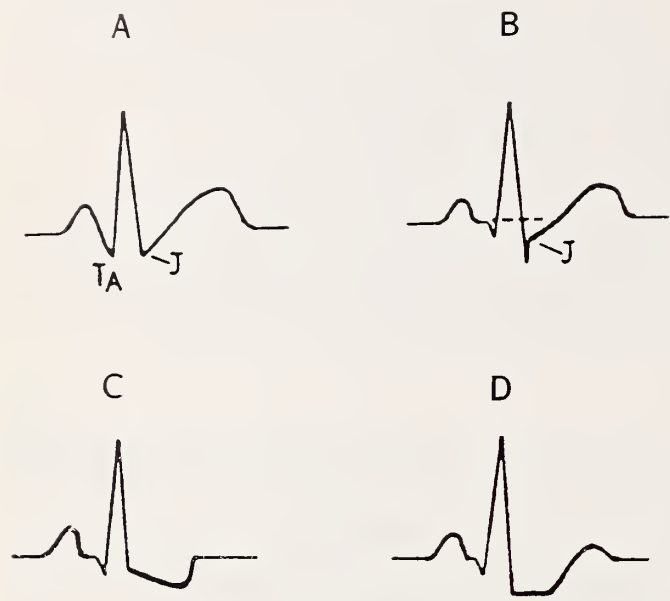


FIGURE 2

Electrocardiographic responses to exercise: (A) Common normal response to exercise demonstrating false junctional depression due to atrial repolarization; (B) True junctional ST depression but with rapid return of the ST segment to the isoelectric line; (C) True J point depression with downward ST slope; (D) True J point depression with horizontal ST segment.

poorly with coronary artery disease. Most authorities require a one millimeter depression as the minimal criterion for a positive test. Fifty-eight per cent of patients with angina pectoris demonstrate a one millimeter or greater ST segment depression, whereas only 28 per cent demonstrate a two millimeter or greater depression.¹⁴ The incidence of false positive tests approaches 39 per cent when using the criterion of one-half millimeter depression to indicate a positive test,⁷ whereas 50 per cent of asymptomatic subjects who have a normal resting ECG, but a one millimeter or greater ischemic depression during submaximal stress can be expected to develop angina or myocardial infarction within five years.⁵ Moreover, the risk of death from coronary artery disease appears to be proportional to the depth of ST segment depression.¹⁵ While segmental depression is not specific for coronary artery disease it does reflect myocardial ischemia. Hellerstein and coworkers⁹ found about as many positive two-step exercise tests in patients with rheumatic heart disease as in patients with a confirmed history of previous myocardial infarction. While the criteria for a positive test were less restrictive than described herein, the incidence of positive response was higher in older patients and those with most severe cardiac hypertrophy. While it is commonly reported that patients taking digitalis may develop ST segment depression with exercise, Hellerstein and coworkers⁹ found

about the same incidence among patients on and off the drug. Moreover, the vast majority of patients on digitalis whose electrocardiograms undergo alterations during exercise do not develop typical sagging or horizontal ST depression. Should typical segmental depression be found, exercise testing should be repeated, if possible, sometime after the discontinuation of digitalis.

In general, patients who are able to complete Bruce Stage 3 testing (Table 1) had a functional capacity equivalent to New York Heart Association Class I; those completing Stage 2 but not Stage 3, Class II; those completing Stage 1 but not Stage 2, Class III; and those failing to finish Stage 1, Class IV. Repeated testing several weeks after instruction and completion of a moderate progressive daily walking program often results in a striking improvement in patient ability to undergo more prolonged exercise.

TABLE 1
MULTISTAGE EXERCISE CAPACITY TEST
(Bruce)

Stage	Speed (M.P.H.)	Grade Per Cent	Duration (Min.)
1	1.7	10	3
2	2.5	12	3
3	3.4	14	3
4	4.2	16	3
5	5.0	18	3
6	5.5	20	3
7	6.0	22	3

Comparison of Tests

Friedberg and coworkers⁷ and Sheffield and associates¹⁷ have found that the Master Test will produce segmental ST depression of one millimeter or greater in only about 50 per cent of patients with classical angina pectoris. Because of the lack of sensitivity of the Master Test, submaximal and maximal exercise testing is being used with increasing frequency. The critical difference between the Master Test and graded exercise testing is the ability to increase workload sufficiently to increase heart rate to the desired end point. Submaximal testing is positive in about 80 per cent of patients with established angina pectoris,¹⁷ while the incidence of positive response is slightly higher with maximal testing.⁸ Mason and coworkers¹⁰ found that 61 per cent of their patients with coronary disease had a positive double Master Test, whereas 85 per cent responded in a positive fashion when tested on a graded ergometer. There is an important positive correlation between a positive exercise test and findings at coronary arteriography. Roitman and coworkers¹⁶ compared submaximal testing with coronary arteriog-

raphy in 100 patients with chest pain. Of the 52 patients with a positive test, 45 had abnormal coronary arteriograms. Of 20 patients with a normal resting ECG and a normal submaximal exercise test, 70 per cent had normal coronary arteriograms, while 30 per cent had some evidence of occlusive disease. Ninety-two per cent of patients with a normal resting ECG but a positive exercise test had coronary obstruction.

Maximal stress testing of apparently normal individuals has been reported to produce ST segment depression in approximately 9 per cent.⁴ Since the incidence of positive responses in this group increased with age, it is likely that many of these patients had nonsymptomatic coronary artery disease. However, while there is a good correlation between the presence of ischemic ST segment depression during exercise and the development of coronary heart disease, exercise testing has only a limited predictive value. Doyle and Kinch⁵ observed 2,003 apparently normal middle aged men for 14 years following submaximal treadmill testing. Only 30 individuals developed one millimeter or greater ST segment depression prior to other manifestations of coronary heart disease, whereas 223 men developed manifestations of coronary heart disease other than or in addition to an abnormal exercise electrocardiogram.

Summary

Exercise stress testing is a valuable and safe supplementary method for the evaluation of cardiac patients. Stress testing of patients with suspected coronary artery disease is a relatively simple method for confirming the diagnosis. However, the usefulness of information obtained is directly related to the degree of exertion experienced by the patient. It is important to achieve a level of effort producing a maximal or submaximal heart rate response prior to concluding that a given patient does not have a positive test indicating coronary ischemia. Moreover, it is likely that the majority of patients with coronary vascular disease will have other manifestations at an earlier date. It thus appears that stress testing is a poor method for detecting asymptomatic ischemic heart disease, but should be reserved for patients in whom other evidence is suggestive. Exercise testing is of great value in evaluating functional capacity and the results of medical and surgical therapy.

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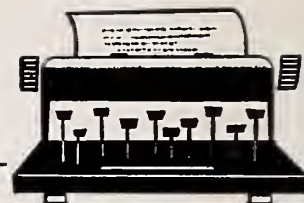
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MEETINGS OF INTEREST

The *Second Seminar on Arthritis* under the co-sponsorship of the Divisions of Rheumatology and Orthopedic Surgery and Department of Physical Medicine of Emory University will be held at Grady Memorial Hospital in Atlanta March 13 and 14.

The Center for Disease Control is sponsoring a national conference on *Current Concepts in Communicable Disease Control* at the Sheraton-Lincoln Hotel in Houston, Texas, March 13-16. Local arrangements and program information are available from J. D. Millar, M.D., Director, State and Community Services Division, CDC.

The 40th Annual Assembly of the *Southeastern Surgical Congress* will be held at the Shoreham Hotel and Motor Inn, Washington, D.C., March 27-30.



*Coronary Atherosclerosis: A Medical or a Surgical Future?**

"It is much easier to write upon a disease than upon a remedy. The former is in the hands of nature, and a faithful observer, with an eye of tolerable judgment cannot fail to delineate a likeness. The latter will ever be subject to the whims, the inaccuracy, and the blunders of mankind."

WILLIAM WITHERING
An Account of the Foxglove

THE PHYSICIAN learns early in his career that you first do no harm. In the area of coronary atherosclerosis this prudent approach has usually meant close observation of the patient and here and there a nudge with a carefully chosen drug.

The advent of coronary artery bypass surgery, however, has brought great controversy and anxiety to our traditional approach to these patients. The enthusiasm by some groups for this surgery and their increasing indications for its application threatens to change the coronary care unit into a pre- and postoperative coronary surgery unit. As the fervor for the procedure increases and as patients read lay magazines proclaiming that the cure for coronary atherosclerosis has arrived in the disguise of a vein, the physician is confronted with the dilemma of medical versus surgical therapy. Perhaps the prudent course is no longer the easy decision of not to operate.

This editorial examines some of the elements of the surgery that a physician must ponder before he selects a medical or surgical future for his patient.

The Candidate

Originally patients were selected because of angina unresponsive to medical therapy. Lately the enthusiasm in certain centers has led to the inclusion of patients with cardiogenic shock, pre-infarction angina, recurrent ventricular arrhythmias, myocardial failure, previous myocardial infarction, and even the asymptomatic patient with significant coronary occlusion. The rationale for operating on the desperately ill patient is similar to the selection of patients for cardiac transplantation—"the patient will die unless something is done." Unfortunately most of us are not gifted with this kind of oracular insight. Often the most ill patients, even those in cardiogenic shock, defy our direst predictions. Arrhythmias, stubborn and recurrent as they may be, are usually subdued given enough medicine and time. The group with pre-infarction angina represent a vexing problem in both diagnosis and treatment. The natural history of this very ill-defined group is not known. A recent report suggests that the one-year prognosis is fairly good without surgery. The group with myocardial failure as their ticket to the surgical arena have been reported to show improvement in some studies but not in others. The ultimate operability of these patients will likely depend on the amount of muscle that is still viable before surgery. There is no information about the asymptomatic group with significant coronary disease. It has been known for some time that it is difficult to make an asymptomatic patient feel better. His risk for a future myocardial infarction is unknown but certainly better at this time than the risk of surgery.

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The Risk of the Procedure

Selective coronary cineangiography is required to identify the location and the extent of the occlusive process. The risk of the angiography is small (20 deaths in 22,600 cineangiograms at the Cleveland Clinic) at the large centers devoted to this technique as a full-time occupation, but probably much higher in the less active centers. Unfortunately, the latter statistics are not available and the risks of the procedure at the local laboratory are assumed to be the same as the large center. It should also be noted that a large percentage (20 per cent at the Cleveland Clinic) of patients are found to have normal arteriograms. These patients are a very low risk group and should not be included in calculating the risk of angiography for patients with serious disease.

The same reasoning should be applied to the surgery. The operation has been accomplished at low risk (3 to 4 per cent at the Cleveland Clinic) but is certainly much higher, probably at least 10 per cent, at other centers. This mortality rate increases according to the number of vessels bypassed, the addition of aneurysmectomy to the surgery, the skill of the surgeon, and the experience of his supporting team. Coronary artery surgery, just as cardiac valvular surgery, requires the full-time, 24-hour-a-day skills of experienced nurses, cardiologists, cardiovascular surgeons, and operating room personnel. This procedure cannot be recommended for the hospital that cannot supply each of these vital components for successful surgery.

Pathologic Requirements

The coronary circulation depends upon three major vessels: the right coronary artery, the left anterior descending and the left circumflex. Each of these vessels can be bypassed if the artery distal to the obstruction is patent and at least 1.5 mm. in size. Since the greatest severity of coronary atherosclerosis is usually proximal, then most obstructed arteries can technically be bypassed. The obstruction must exceed 75 per cent of the lumen visualized on angiography or the graft will probably not remain open. In addition, there is evidence that blood flow does not become significantly limited until the vessel is 75 per cent obstructed.

An optimum lesion would be a proximal lesion isolated to one coronary artery. Although this may occur, particularly in Prinzmetal's angina, usually two, and sometimes three coronary arteries must be bypassed. Left coronary artery obstruction proximal to the bifurcation of the circumflex and anterior descending arteries has been found to have a particularly ominous prognosis and may require surgery without delay.

The Results of the Surgery

In contrast to previous revascularization procedures such as internal mammary implantation and talcum powder salting of the pericardial sac, coronary artery bypass surgery has a physiologic appeal. Flowmeter techniques have documented a graft flow of 70 to 110 cc/minute. Cineangiography has demonstrated patency of the graft. Patients with incapacitating, recurrent angina refractory to excellent medical therapy have offered testimonials of complete relief. Pre- and postsurgical treadmill exercise studies have also documented the clinical improvement.

On the other hand, the long-term fate of the grafts is not yet known. The most experienced surgical groups report closure of 15 to 20 per cent of the grafts a variable period postoperatively. Recently there have been reports of intimal hyperplasia in the grafted veins resulting in occlusion. Because of this possible unsuitable performance of a vein graft connection between two arteries, some surgeons are switching their allegiance to direct anastomosis from the internal mammary artery to the coronary artery. A number of the patients who have attested to complete relief of chest pain have been shown to have an occluded graft on restudy. Most distressing has been the report of progressive atherosclerosis distal to the graft. Although the procedure may improve angina pectoris, it is not known if the procedure prolongs life. Unfortunately, we still do not know the natural history

of unoperated patients with angina pectoris for comparison with the surgical results.

Summary

At this time I believe that the procedure should be recommended to the patient with angina recalcitrant to careful medical management. Hopefully the next several years will bring information about the long-term patency of veins or arteries used as bypass grafts. The prognosis of the various groups described earlier should be clarified. Large scale clinical studies should reveal whether the procedure enhances the quality and the quantity of life. Until these studies are available, I will maintain some reservations about extending the procedure more widely, hoping, as did Sir Francis Bacon,

"If a man will begin with certainties, he shall end in doubt, but if he will be content to begin with doubts, he shall end in certainties."

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Georgia Heart Association Activities

FEBRUARY IS Georgia Heart Month. It is a time to focus attention not only on the vast problem of cardiovascular disease, which annually claims more than 50 per cent of all lives lost in Georgia, but also on the one organization in our state devoted exclusively to combatting this killer.

The Georgia Heart Association has met this overriding health menace by bringing together the knowledge and energy of medical and nonmedical volunteers to evaluate, develop and implement multi-faceted programs aimed at reducing premature death caused by heart disease.

In a long-established partnership, more than 1,000 physicians and 400 nurses last year worked with nonmedical leaders as members of the GHA. In addition to the membership force, the services of thousands more medical people were enlisted to carry through these vital programs.

In an age of increasing public concern over health and related matters, the GHA has afforded an opportunity for involvement for medical people throughout the state.

Operating under a three-year grant from the Georgia Regional Medical Program, the GHA trained 17,000 Georgians in the lifesaving technique of cardiopulmonary resuscitation (CPR). Of those trained, 2,500 took advanced courses to become instructors in the program and organize similar courses in their own communities for people in high risk and emergency occupations. In-service training programs are operating in 120 Georgia hospitals, representing 80 per cent of the state's total hospital beds. After termination of the grant last August, the GHA assumed full responsibility for the program.

The GHA directed more than \$200,000 to heart research in Georgia institutions last year and to the national research program of the American Heart Association which is currently supporting four research grants in Georgia.

One hundred and twenty-one professional nurses actively involved in the care of cardiac patients and operating in hospital-teaching capacities attended the annual cardiology seminar of the GHA to learn rehabilitation techniques for heart attack

patients and incorporate their learning into nursing courses in their own areas.

Three hundred Georgia physicians and professional nurses attended the annual scientific sessions to hear leading national experts in the field of cardiovascular disease discuss the latest advancements in diagnosis, treatment and rehabilitation of cardiac patients.

One hundred and eighty volunteer physicians gave more than 8,000 hours of free professional time and service in 14 heart clinics to administer medical treatment to the indigent. The Georgia Heart Clinic System now handles about 20,000 patient visits every year and by working with other health agencies, makes possible advanced diagnosis, treatment and surgery for patients who cannot afford to pay for it.

In other areas of Heart Association activity, as many as 244 Georgia firms employing 140,000 employees have participated in an intensive "Heart of Industry" program to make employees aware of the factors which can reduce their risk of heart attack. Hundreds of volunteer physician speakers took part in the program, using thousands of brochures, films and other educational materials provided by the GHA.

Risk factor programs on smoking, diet, high blood pressure and exercise were presented all over the state by volunteers for the GHA, and 349,000 pieces of free heart literature were sent in response to requests from 3,500 physicians, nurses, teachers, students, people in industry and others interested in the problems of heart disease.

These activities indicate, but never can measure fully, the value of the countless hours freely given by thousands of physicians and nurses in the state.

The Georgia Heart Association is a tool, made possible by public support, through which leaders in business and medicine can channel all available knowledge toward one goal—conquest of heart disease. Medical volunteers have used this tool well in Georgia and by doing so have benefited not only the public, but the entire medical profession as a whole.

TAPES AVAILABLE

Cassette tape recordings of the program of the Cobb County Medical Society, November 20, 1971, sponsored by Lederle Laboratories, are available with the following features and speakers:

Tape No. 1

"The Physician as a Father"—Joseph B. Trainer, M.D., Professor of Medicine, Associate Professor of Physiology, University of Oregon Medical School, Portland (40 minutes).

"On Being the Husband of a Physician's Wife"—Beverley T. Mead, M.D., Professor and Chairman, Departments of Psychiatry and Neurology, The Creighton University School of Medicine, Omaha (40 minutes).

Tape No. 2

"The Physician as Doctor and Patient"—Perry Scott MacNeal, M.D., Physician to Pennsylvania Hospital and Benjamin Franklin Clinic, Philadelphia (40 minutes).

"The Physician as a Citizen and Community Leader"—Joseph B. Trainer, M.D. (40 minutes).

Tape No. 3

"The Battle of the Sexes" (A humorous and perceptive commentary)—Beverley T. Mead, M.D. (1 hour).

Tape No. 4

"How to Be Successfully Married to a Doctor Without Resorting to Violence"—Mrs. Ruth Inglis, Doctor's Wife, Mother, Civic Worker, and Writer, Marietta (40 minutes).

"The Realization of a Physician as a Man"—Perry Scott MacNeal, M.D. (40 minutes).

Tape No. 5

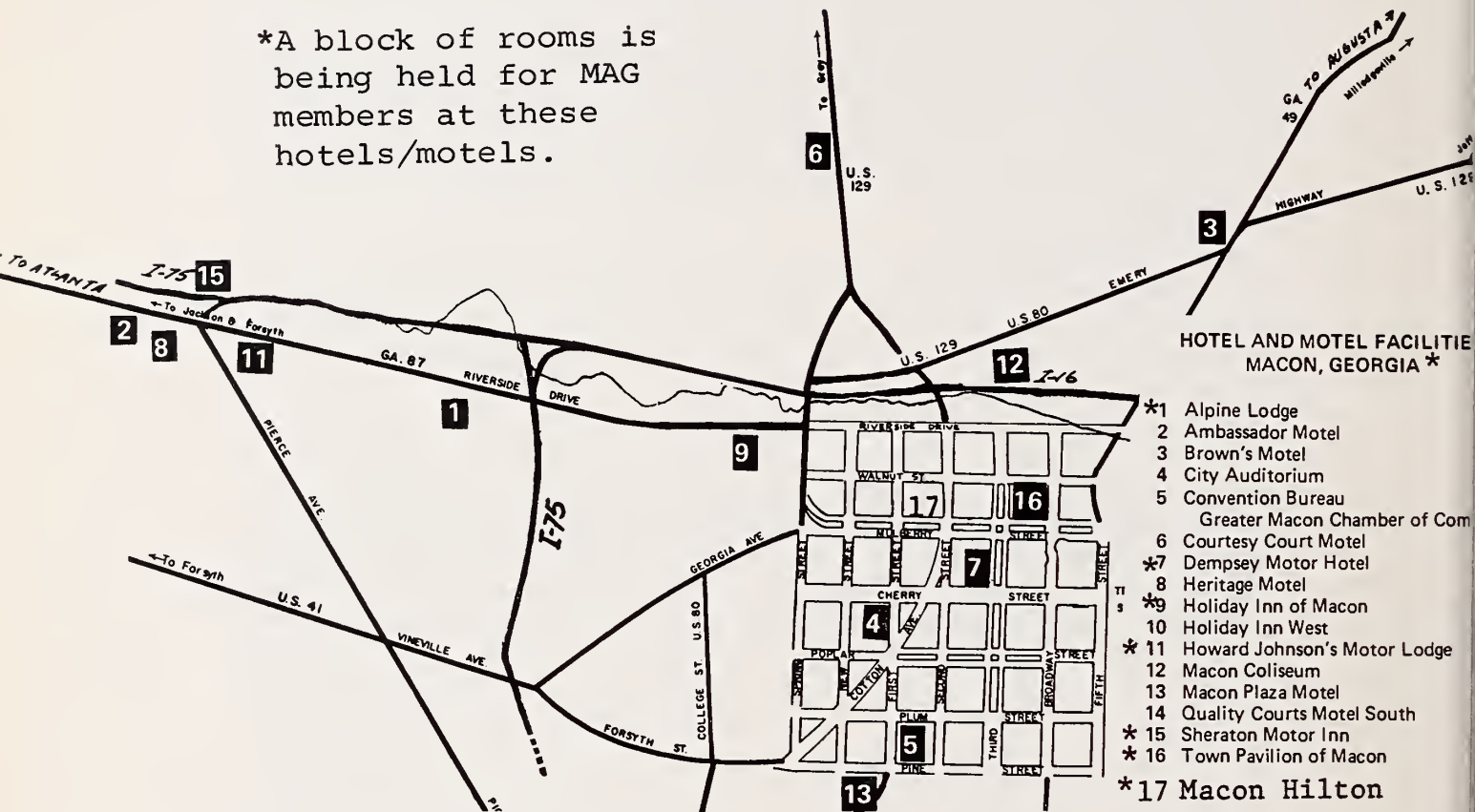
Panel Discussion—All the above speakers (1 hour).
Cost per tape is \$3.50. Your check made payable to the Cobb County Medical Society should accompany your order. Address all orders to

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1972 Annual Session

LOCATION OF HOTELS AND MOTELS IN MACON

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THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 11, 1972

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 12, 1972

- 9:00 a.m.—First General Session
First Session, House of Delegates
Featured Speaker: "Government Controlled Medical Care"
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Health Care Delivery Systems—Past, Present and Future"

6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 13, 1972

- 9:00 a.m.—Reference Committee Meetings
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Venereal Disease," "Sex in Schools" and "Dynamics of Violence"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 14, 1972

- 7:00 a.m.—Prayer Breakfast
- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia

Annual Session

May 11-14, 1972—Macon, Georgia
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- 4. Unreserved accommodations will be released on April 20, 1972.
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Howard Johnson's Motor Lodge 2566 Riverside Dr., Macon, Ga. 31202	Single—\$13.00-16.00 Double—\$18.00-21.00	\$3.00 \$3.00
Macon Hilton Hotel P.O. Box 144, Macon, Ga. 31202	Single—\$17.00 Double—\$23.00	\$6.00 \$6.00
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MAY 11-14, 1972

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WITH YOUR PERMISSION

I'D LIKE TO TAKE this opportunity to commend Dr. Edgar Woody, Jr., Mrs. Pat Thigpen Phillips and their staff on the splendid job that has been done in the past in putting together our *Journal* and getting it to us each month.

There's more to getting out a monthly journal of this type than meets the eye. The monthly contributors have to be constantly prodded to get their material in on time. Then this material has to be edited and checked for spelling and punctuation and lines counted in order for it to fit in the space allotted. This, along with the scientific articles, news items and advertising, has to be organized and sent to the printer.

As you see, this all takes time, and the articles for this month's *Journal* were supposed to be in before the 10th of last month. I'm prefacing what I'd like to say in this month's President's Page with the above in order for you to know that events that have occurred and been reported in your *Journal* have quite often happened four to six weeks before you read it here.

In the mail of January 10, I received a printed reproduced copy of a letter that was mailed from the Executive Department of the Capitol bearing the date of January 6 and postmarked in Atlanta on January 8. This was a two-page letter signed by the Governor and addressed to your President at the headquarters office, 938 Peachtree Street, NE, Atlanta, Georgia. I'm sure most of you received the same two propaganda sheets with no cover letter of explanation.

The original of this letter was received at the MAG Office on January 11. (It was still postmarked on the 8th, but it seems to take mail a day longer to be delivered in Atlanta than elsewhere.) As you recall, the letter ended with a final paragraph that read, "*With your permission*, this letter is being sent to other doctors. You are all heirs to a long tradition of selfless and dedicated service to those in need. I admire and appreciate that great heritage and on that basis I ask for support."

I want to assure you, as your President, that this permission was neither asked for nor granted. I'm assuming that those in positions of power are presumptuous enough to *assume* this permission. Or it could have been that they were in such a hurry to get the letter out so it could be one of the political last-day pressure sheets, it would give nobody time to refute it.

It appears to me that the timing had to be figured out, since the Legislature convened on January 10 and this letter—conveying an implied impression that it had the blessing of your President and the Medical Association and asking for our help in putting his program over, perhaps indicating a change in the position of the MAG—arrived on that date. Since with this implied impression, you could be inclined to take the pressure off your Legislators to back up the MAG position of opposition to the program as presented, don't you get the feeling that the timing was indeed important?

My first thought was to get out an all-member mailing regarding this unethical political statement. I'm sure that it cost the taxpayers several hundred dollars for this letter to be mailed, and knowing that it would cost us a like amount, I did not feel that we should take MAG funds to try to counteract that for which taxpayer's funds were used. I well remember when Sam Wong—a Chinese—shot and killed his wife—Susie Wong—when she presented him with a white baby. His statement was, "Two Wongs don't make a white."

I'm sure you noticed in the contents of this letter that the statement is made that "some irresponsible opponents of reorganization . . ." and I presume all of us who have consistently opposed the abolition of the State Board of Health are the ones referred to as being irresponsible.

I feel that the letter defeated its purpose because there were many of the recipients who felt that the letter had been missent because of the heading and they simply dropped it in another envelope and mailed it to me at the MAG office.

To me, the whole thing was an example of power politics and I feel it was worthy of a good chuckle. I hope you took it in the same vein. If standing up for what one feels is right and should be done classes one as being irresponsible, I will have to say that the shoe fits and I will be glad to wear it with pride.

See you next month.

W.C. Mitchell

W. C. Mitchell, M.D.
President, Medical Association of Ga.

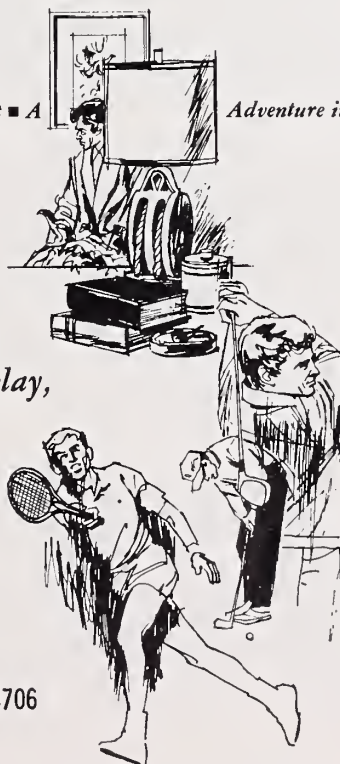
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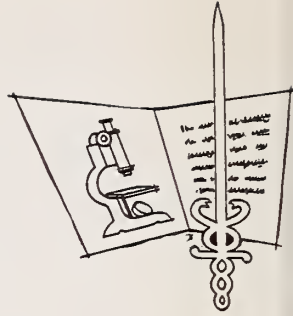
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IS THE DOCTOR REALLY RESPONSIBLE?

J. BENHAM STEWART, M.D., *Macon*

“I WOULD QUIT SMOKING but no one has ever told me to.” How many times have you heard this in your office, particularly when you ask the patients how much they smoke or why do they smoke when they have a definite lesion in their mouth or a dry hacking cough? This statement is not much more common than the question. “Do you really think smoking causes cancer?” These are situations that have to be faced by a patient frequently in this day and time, and the question is, where does the doctor’s responsibility start and stop?

We as doctors have all of the facts at our fingertips, the approximate number of patients that will die of lung cancer, the fact that oral and laryngeal cancers are directly related to smoking and the fact that peptic ulcer disease and even heart disease are directly related to smoking. For this reason I feel that we need to take a closer look at our responsibility to our patients.

It is indeed a flimsy excuse to say that you would do what is right if some one would just tell you to do it, and this is, in effect, what people are saying. Even so, people do depend on their doctors for advice on medical matters and many of them feel that they have no responsibility whatever for their health, but that it is up to their doctors to take the lead and see to it that they get what they should have. The lay press and the politicians are becoming increasingly vocal about this. Shouldn’t we?

It would also be nice to carry this a little further and say that doctors should probably urge their patients to have a physical examination once a year which includes a sigmoidoscopic examination and Pap smear. Most of these, of course, turn out to be negative, but the few who turn up with early pathological processes which are easily curable, make it worth going through all the other examinations.

700 Spring St.



EXERCISE STRESS TESTING IN CLINICAL PRACTICE

MILTON FRANK, III, M.D., *Atlanta*

IN RECENT YEARS exercise stress testing techniques have been developed which can assist the clinician in his diagnosis and management of coronary heart disease. Exercise testing techniques basically include step climbing (i.e., Master Test), treadmill walking, and bicycle ergometer exercise.

Recent studies have conclusively demonstrated that treadmill exercise testing produces a more sensitive and specific noninvasive diagnosis of arteriosclerotic coronary artery disease than is available through a double Master Step Test.

Treadmill exercise testing protocols include continuous walking at a predetermined speed and grade on elevation from the horizontal. The treadmill speed and grade are increased at one- to three-minute intervals and the patient can be exercised to the limit of his capacity (Bruce Test) or can be exercised to a predetermined heart rate which is 85 per cent of his predicted maximal capacity and then maintained at such an exercise level for two minutes (Graded-Exercise Test).

Each patient should have a chest and cardiac examination and a resting electrocardiogram prior to testing. Contraindications to testing include: 1) History of recent myocardial disease, 2) a change in the pattern of angina pectoris, 3) any serious arrhythmia, and 4) any acute non-cardiac disease. During the test, the electrocardiogram is continuously monitored and the blood pressure is determined at each level of increasing exercise. The patient is closely observed for the appearance of chest pain, cerebral ischemia, ischemic leg pain, fatigue, undue dyspnea, cyanosis or pallor, any of which warrants discontinuing the test. If there is a fall in blood pressure or reduction in heart rate as the exercise level is increased, the test should be stopped. The test should be discontinued when significant EKG abnormalities such as progressive S-T depression or S-T elevation, serious dysrhythmias (including sustained tachyarrhythmias, multiple and multifocal PVC's, and atrioventricular block) or complete bundle branch block appear and were not present in the resting pre-exercise state.

A positive test for arteriosclerotic heart disease requires 1.0 mm. of horizontal or down sloping S-T depression below the level of the P-R segment at the onset of the QRS. S-T depression of 0.05 mm. to 0.1 mm. constitutes a borderline test. These S-T abnormalities may appear when rapid heart rates occur, but, more commonly, are detected in the postexercise period. Therefore, during the immediate postexercise period and during the ensuing six to eight minutes, periodic ECG monitoring is required.

Because an exercise stress test is a provocative test for ischemic heart disease, safety measures must include electrocardiographic monitoring equipment, a DC defibrillator, and a staff trained in cardiopulmonary resuscitation and in arrhythmia detection. In a recent survey of 170,000 exercise tests, mortality (1/10,000 tests) and morbidity (2.4/10,000) rates were exceedingly low.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Exercise stress testing has become an important aid in assessing the physical conditioning of asymptomatic men and women prior to their participation in executive fitness programs. Latent coronary artery disease may also be discovered and a more cautious fitness program can be tailored to the affected individual.

In the asymptomatic, postmyocardial infarction patient, cautious exercise testing can provide evidence of his capacity for initiating a physical rehabilitative program with a goal of returning to his previous occupation. Periodic testing during a rehabilitative program will enable the physician to more confidently advise the patient regarding when he should return to work and at what work level he can safely perform. In a variety of chronic cardiac diseases exercise testing is proving useful in assessing the benefits of medical and surgical therapy.

1175 Peachtree St., N.E.

HIGHLIGHTS OF GEORGIA
MEDICAL CARE FOUNDATION
BOARD OF DIRECTORS MEETING

January 9, 1972, Atlanta

Treasurer's Report: The report was accepted. It was voted to set aside an additional amount in escrow for consultant physicians and to contact legal consultants and auditors to ascertain that reimbursement to MAG as a line item in the expenses designated as MAG management and supervision was proper.

Atlanta Blue Shield: The proposed Atlanta Blue Shield Contract with changes in cost figures will be submitted to Blue Shield for comments.

MAG Blue Cross-Blue Shield Group Insurance Plan: The two Blue Cross-Blue Shield Plans could not agree on a single plan, but two developmental plans had been presented by the two plans; Atlanta's based on a percent of U.C.R., and Columbus' based on a modified P.S.I., times 6.16.

Negotiations will continue with the carriers for provisions for Foundation review and acceptable schedules.

Columbus Blue Shield: It was reported that Columbus Blue Shield has requested county medical societies in its area to form peer review committees in conflict with the MAG and Foundation peer review system. The Board requested that staff notify all county societies of the MAG and Foundation position on peer review. Staff was also requested to notify the Columbus Blue Shield of the MAG and Foundation opposition to their proposal.

EMCRO: Recent activities of the Experimental Medical Care Review Organization were described for the Board.

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THE ASSOCIATION

PERSONALS

First District

William H. Lippitt of Savannah was named president-elect of the Georgia Medical Society and will take office in December. **Darnell Brawner** was installed as president. Other elected officers were: **Edwin C. Shepherd**, vice president; **Harry McGee, Jr.**, secretary and **Dearing Nash**, treasurer.

Fifth District

Charles E. Todd has been installed as president of the Medical Association of Atlanta. Other new officers elected are: **Harrison L. Rogers, Jr.**, vice president; **Joseph L. Girardeau**, secretary; **L. Newton Turk, III**, treasurer.

H. Harlan Stone, associate professor of surgery at Emory University School of Medicine, is co-editor of a new book "Contemporary Burn Management" to be published by Little, Brown.

Ninth District

C. J. Walker, Jr. was elected president of the Hall County Medical Society to succeed **W. D. Stribling, III**, the new chief of staff at Hall County Hospital in Gainesville.

DEATHS

Percy O. Chaudron

Percy O. Chaudron, age 85, of Cedartown died at Emory University Hospital in Atlanta December 21.

Dr. Chaudron retired from active practice after 60 years of service. He was a member of the vestry of the St. James Episcopal Church, Director of the Liberty National Bank in Cedartown, a Mason, Kiwanian and member of the American Legion.

He is survived by one daughter, Mrs. Wallace H. Stewart of Atlanta; three sisters and three grandchildren.

George H. Lang

George Herman Lang died at Candler General Hospital in Savannah January 3 at the age of 85.

A native Savannahian, Dr. Lang graduated from University of Virginia Medical School, interned at Walker Memorial Hospital in Wilmington, N.C. and joined the staff of the Manhattan Eye, Ear, Nose and Throat Hospital in New York City. He was a captain in the Army Medical Corps during World War I.

During his 42 years of active practice in Savannah, he served as president of the Savannah-Chatham

Health Council, lay vice-president of the Lutheran Church of the Ascension and a member of the Georgia Medical Society.

He was also a member of the American Academy of Ophthalmology, the American Medical Association and a fellow of the American College of Surgeons.

Dr. Lang is survived by his wife Mrs. Lois Artley Lang; a daughter, Mrs. Carlton B. Gibson of Larchmont, N.Y. and two grandchildren.

J. Paul Lindsay

J. Paul Lindsay, 55, Director of Emergency Services at Georgia Baptist Hospital died January 10 at his home in Decatur.

Dr. Lindsay, a native of Tennessee, graduated from University of Tennessee, received his Master's degree from George Peabody College and his M.D. from Vanderbilt University.

He was a veteran of both World War II and the Korean Conflict. Since 1968, Dr. Lindsay had been consultant to the U.S. Department of Health, Education and Welfare on medical affairs.

He was a former associate director of the Department of Preventive Medicine at Memorial Sloan-Kettering Institute in New York and a member of the American Medical Association Committee on Continuing Education.

He is survived by his widow, two daughters, three sons and a brother.

Scott L. Tarplee, Sr.

Scott L. Tarplee, Sr., died January 4 at his Atlanta home.

Dr. Tarplee was born in Cartersville and lived in Atlanta most of his life.

He was a graduate of Emory University School of Medicine and a member of the American Medical Association.

Survivors include his widow, a daughter and a son.

Hudnall Gentry Weaver

Hudnall Gentry Weaver died in a Macon Hospital at the age of 74 on December 23.

An alumnus of Mercer University, Dr. Weaver graduated from Medical College of Georgia in 1920. He served on the Bibb County Board of Education as a member for 30 years and held office during that time as secretary, vice president and president.

Dr. Gentry was a member of the Vineville Baptist Church, the Macon Kiwanis Club, the Elks and Idle Hour Country Club. He was also a Mason, former Vice President of the Medical Association of Georgia, counselor for the sixth district MAG, member and past president of the Bibb County Medical Society and physician for the Masonic Home of Georgia.

He is survived by his widow, Margaret Smith Weaver, two daughters and two grandchildren.

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118TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Macon, Georgia, May 11-14, 1972

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee

938 Peachtree Street, N.E. • Atlanta, Georgia 30309

*Space is limited at the Macon Hilton and requests for applications should be made early to establish priority.

JOURNAL
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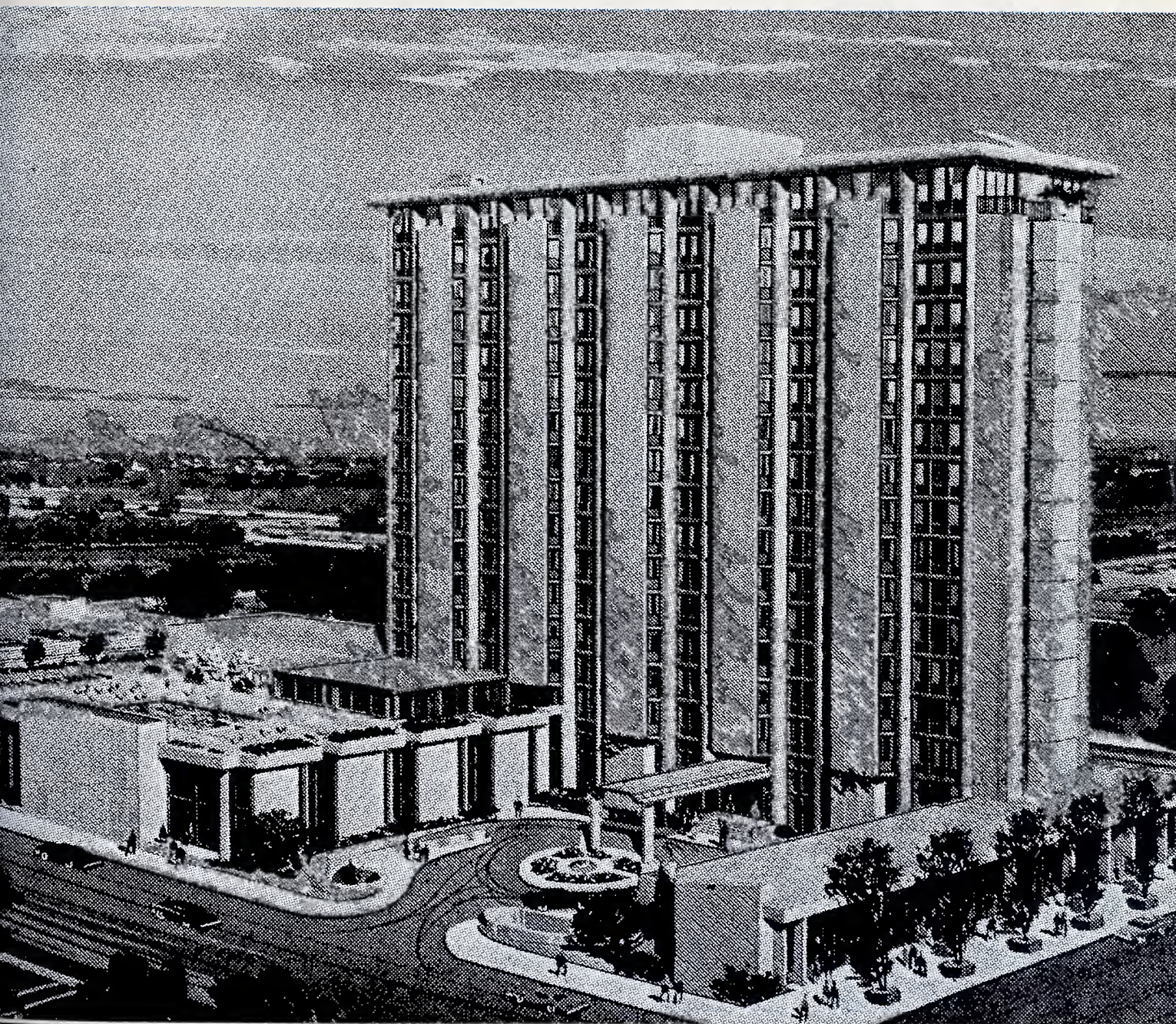
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18th ANNUAL SESSION



MAY 11-14th, 1972 • HEADQUARTERS: HILTON HOTEL, MACON



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ducing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

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JOURNAL OF THE MEDICAL ASSOCIATION

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Contents

1972 MAG Annual Session

OFFICIAL CALL	67
OFFICERS AND COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA	72
OFFICIAL PROGRAM	74
SPECIALTY SOCIETY MEETINGS AND SOCIAL EVENTS	76
WOMAN'S AUXILIARY—THE PROGRAM AND OTHER DATA	80
HOTEL RESERVATIONS	115

Scientific Articles

RENAL OSTEODYSTROPHY Albert A. Carr, M.D., B. R. Sharpton, M.D., Robert E. Dicks, B.S. and T. E. Temple, Jr., M.D.	89
PORPHYRIA Stewart E. Wiegand, M.S., M.D.	99
A COMPARISON OF CLINDAMYCIN AND ERYTHROMYCIN IN BETA-HEMOLYTIC STREPTOCOCCAL INFECTIONS Michael K. Levine, M.D. and Jerome D. Berman, M.D.	108

Editorials

WELCOME TO MACON L. E. Dickey, M.D.	112
PROSTAGLANDINS Donald O. Nutter, M.D.	112

Features

President's Letter	116
Cancer Page	118
Heart Page	120

The Association

New Members	122
Societies	122
Personals	122
Deaths	123

Cover

MAG Annual Session Headquarters Hotel. Design by Robert Hamill.

118th Annual Session Official Call

*Extended to All Officers and Members
of the Medical Association of Georgia*

WELCOME TO THE 118TH ANNUAL SESSION of the Medical Association of Georgia, at Macon, the "Heart of Georgia."

General Sessions

The opening session will be called to order by W. C. Mitchell, M.D., Smyrna, President of the Association, at 9:00 a.m., Friday, May 12, in the Ballroom of the Macon Hilton Hotel, with the Presentation of Colors and a rendition of "God Bless America," by Mrs. John Grenga. A Welcome by the Bibb County Medical Society President, L. E. Dickey, M.D., will be followed by a Welcome to Macon by the Mayor of the city of Macon. Reports from the Woman's Auxiliary and the Georgia Student American Medical Association Chapter Presidents will follow. The President-Elect's Address will be a feature of this Session.

The Final General Session on Sunday, May 14, at 9:00 a.m., features a religious observance, a Memorial Service, the Presentation of Certificates of Appreciation, Life and Fifty Year Membership Certificates and the Distinguished Service Award. The drawing of the name of the winner of the Commercial Exhibits Visitation Award will be held. Announcement of the site of the 1978 and 1979 Annual Sessions will be made. Immediately following the adjournment of the Second Session of the House of Delegates, the Final Session will reconvene for the Installation of Officers and Adjournment of the 118th Annual Session.

General Meetings

On Friday afternoon a panel on "Health Care Delivery Systems—Past, Present and Future" will be presented with Russell B. Roth, M.D., Erie, Pennsylvania, Speaker of the AMA House of Delegates; Paul Sanazaro, M.D., Rockville, Maryland, Director, National Center for Health Services Research and Development of the Department of Health, Education and Welfare; and Wesley W. Hall, Jr. M.D., Reno, Nevada, son of the President of the American Medical Association, as panel members. On Saturday

there will be three speakers. "The Management of Syphilis and Gonorrhea" will be presented by William J. Brown, M.D., Atlanta, Medical Consultant, VD Center, CDC Regional Office, Department of Health, Education and Welfare; Melvin Anchell, M.D., Los Angeles, author and member of the American Board of Family Physicians, will speak on "Sex in Schools"; and Jan Alan Fawcett, M.D., Chicago, Associate Director of Research, Illinois State Psychiatric Institute, will speak on "Dynamics of Violence."

Registration

A general registration desk for all participants will be open in the Macon Hilton Hotel on Thursday, May 11, from 8:30 a.m. to 5:00 p.m.; on Friday and Saturday, from 8:00 a.m. to 5:00 p.m.; and on Sunday, from 8:00 a.m. to 12:00 noon. Admissions to meetings and exhibits will be by registration badge only.

Council

The MAG Executive Committee of Council will meet at 10:00 a.m. on Wednesday, May 10, in the Walnut Room of the Macon Hilton, and the Council Meeting is scheduled for 2:00 p.m. in the same room. There will also be an Organizational Meeting of Council held following the adjournment of the Annual Session on Sunday, May 14, in the Ballroom.

Reference Committees

All members are invited to appear before the Reference Committees of the House of Delegates on any business being considered by the House. Reference Committees will meet from 9:00 a.m. to 12:00 noon, Saturday, May 13, in assigned rooms at the Macon Hilton Hotel.

House of Delegates

The First Session of the House of Delegates will convene on Friday, May 12, at 9:00 a.m., in the Ballroom of the Macon Hilton Hotel, immediately following the First General Session, at which time nominations of MAG Officers will be made. The Second Meeting of the House will be convened on

Sunday, May 14, in the same location at 9:00 a.m. The Reference Committee reports will be heard. House actions and voting for MAG Officers will take place.

Prayer Breakfast

For the first time, the MAG Committee on Medicine and Religion under the Chairmanship of Dr. W. H. Pool, of Augusta, will sponsor a Prayer Breakfast on Sunday, May 14, 7:00 a.m., in the Elm-Cherry rooms, of the Hilton. A discussion on "Treatment of the Whole Patient" will feature Professor Charles R. Brewster, Macon, Associate Professor, in the Religion Department of Mercer University, and Dr. M. D. Pittard, Toccoa, a member of the MAG Committee on Medicine and Religion. This Breakfast is open to all who are interested, and has been appropriately scheduled to accommodate the officers and delegates prior to the opening of the last Session. Tickets for this event will be on sale at the Registration Desk.

Special Feature

At noon on Friday, May 12, there will be a special program featuring H. E. Godfrey, M.D., of Manchester, England, who will speak on "Government Controlled Medical Care." He may be heard in the Ballroom of the Macon Hilton Hotel.

Fifty Year and Life Members

Physicians to be awarded Life Membership and those who have practiced medicine for 50 years will be honored at the Final General Session, Sunday, May 14, at 9:00 a.m., in the Ballroom of the Macon Hilton Hotel.

Life Members

H. H. Allen	Decatur
J. Rufus Evans	Stone Mountain
W. R. Garner	Gainesville
Willard R. Golsan	Macon
E. Leonard Graydon	Atlanta
William G. Hamm	Atlanta
J. Fletcher Hanson	Macon
M. A. Hubert	Athens
W. O. Martin, Jr.	Atlanta
Carl P. Savage	Montezuma
Calvin B. Stewart	Atlanta
J. W. Thurmond	Augusta
George A. Williams	Atlanta

50 Year Members

Cecil Brannen, Commercial Building, Moultrie
James H. Byram, 3080 Ridgewood Rd., N.W., Atlanta
Charles W. Daniels, 1647 N. Rock Springs Rd., N.E., Atlanta
James K. Fancher, 31 Muscogee Ave., N.E., Apt. 6, Atlanta
Frederick D. Funderburg, Monticello
Lewis D. Hoppe, 4950 Riverview Rd., N.W., Atlanta
Zachariah W. Jackson, 1956 N. Ridgeway Rd., N.E., Atlanta

Henry G. Mealing, 301 South Finance Building, Augusta
Curtis D. Vinson, Route 1, Lizella
William C. Warren, Jr., 490 Peachtree St., N.E., Atlanta
Richard B. Wilson, 47 Interlochen Dr., N.E., Atlanta

Memorial Service

The Association will hold its traditional annual Memorial Service at the Final General Session on Sunday morning, May 14, in the Ballroom of the Macon Hilton Hotel. The event will honor and recall the service and contributions of those deceased members in the past year.

Deceased Members

William W. Aiken, Lyons, August 9, 1971
Robert T. Anderson, Dublin, December 1, 1971
J. D. Applewhite, Macon, November 7, 1971
E. T. Arnold, Jr., Hogansville, May 8, 1971
Cecil N. Brannen, Moultrie, November 28, 1971
Walter H. Bush, Macon, June 6, 1971
Guy L. Calk, Atlanta, November 5, 1971
P. O. Chaudron, Cedartown, December 21, 1971
R. E. Dyer, Atlanta, June 2, 1971
William R. Edwards, Jr., Atlanta, September 1, 1971
Richard S. Graves, Winder, December 11, 1971
A. C. Hohn, Atlanta, October 21, 1971
Robert E. Huie, Decatur, November 8, 1971
Conway Hunter, Atlanta, September 7, 1971
David F. James, Atlanta, July 26, 1971
A. M. Knight, Jr., Waycross, October 18, 1971
G. H. Lang, Savannah, January 3, 1972
John P. Lindsey, Decatur, January 10, 1972
F. M. Martin, Shellman, November 10, 1971
A. I. Miller, Marietta, July 15, 1971
James F. Olley, Atlanta, February 13, 1972
Vernon E. Powell, Atlanta, October 4, 1971
Albert A. Rosenberg, Atlanta, December 9, 1971
Scott L. Tarplee, Atlanta, January 4, 1972
Frank H. Thomas, Valdosta, October 18, 1971
Ernest Thompson, Marietta, July 14, 1971
Angvald Vickoren, Forest Park, January 21, 1972
H. G. Weaver, Macon, December 22, 1971
L. L. Whitley, Athens, December 2, 1971

MAG Message Center

A message center will be maintained near the MAG Official Registration Desk for the convenience of the Membership. Pages from the Woman's Auxiliary will staff this center during the entire Session for incoming messages only. A bulletin board at this message center will be available for notices of special importance during the Annual Session.

MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office in the Iris Room of the Macon Hilton Hotel.
A MAG Press Room will be available in the Iris Room for newspaper, radio and TV personnel.

Hotel Reservations

Officers, Councilors, special out-of-state guest speakers, and Delegates to the MAG House of Dele-

gates will be housed in a reserved block of rooms at the Macon Hilton. Special reservation forms will be issued to the above by the MAG Headquarters Office. The other motels holding rooms for the Annual Session are listed on the reservation page of the *Journal-MAG*. Please request accommodations directly to the motel of your choice.

Elections

The nominations of Officers of the Association, AMA Delegates and Alternates, as well as the announcement of the Family Physician of the Year, will be the order of business in the First Session of the House of Delegates on Friday, May 12. Delegates at the Second Session of the House on Sunday will elect the Officers, AMA Delegates and Alternates, with installation at the Final General Session immediately following the adjournment of the House of Delegates. The Delegates Handbook will list the position vacancies.

Specialty Society Meetings and Social Events

The Specialty Societies have planned meetings, both business and scientific, luncheons, receptions and dinners, for the membership of their organizations, to be held in conjunction with the Annual Session. These events are listed in the Official Program under "Specialty Society Meetings and Social Events" with the date and time of the event.

Bibb County Medical Society Social Hour

The host society invites the membership and their wives to be their guests for cocktails on Saturday evening, May 13, from 6:30 p.m. to 8:00 p.m., preceding the Annual Banquet. The affair will be held in the Elm-Mulberry Rooms of the Macon Hilton Hotel. The sponsors will be the Georgia Bank and Trust Company of Macon and the Security Life Insurance Company of Georgia.

Annual Banquet

The Association will honor its President at the traditional Annual Banquet to be held Saturday evening, May 13, at 8:00 p.m., immediately following the Bibb County Medical Society Social Hour, in the Ballroom of the Macon Hilton. The Incoming President is installed and awards made. Outstanding entertainment is planned at this banquet. The "Gaslight Road Shows" with Dixieland jazz and the original flappers doing the "Charleston" will be the entertainment for the evening. The Hardman and Civic Endeavor Awards will be made at this time, and the Scientific Exhibit and Special Activities Awards will be presented. Prizes for the Art Show and the Antique Car Exhibits are given at the Banquet also. Dress will be semi-formal.

Alumni Events

The Alumni Receptions and Dinners of the two Georgia medical schools, as well as other medical alumni, will be held on Friday evening, May 12. These are listed in the Program under the heading of Alumni Events.

Athletic Events

The annual MAG golf tournament will be held at the Idle Hour Country Club on Thursday, Friday or Saturday, May 11, 12 or 13. Dr. Richard L. Hanberry, Jr., will serve as Chairman. No official handicap will be requested for entry and contestants may form their own foursomes, or singles and twosomes will be paired together if desired. Prizes will be awarded for low net, low gross (Callaway System). Bring your golf clubs and join the fun. There will be a tournament for the ladies also.

Arrangements have been made for the tennis tournament to be held on Thursday afternoon, May 11, for the men and on Friday morning, May 12, for the ladies, at the Tatnall Square Tennis Center, across the park from Mercer University. The tournament will consist of round robin doubles and singles if enough doctors and their wives enter.

Medical Mile details will be announced. For information, contact Dr. W. O. Williams, Jr., Macon, or Dr. Carson Burgsteiner, Savannah.

Art Show

Each year the art show improves with more participation and interest in all categories. The exhibits will be on display in the Grand Foyer area of the Macon Hilton where the Commercial Exhibits are displayed. Prizes will be given for the First, Second, Third and Honorable Mention places in the show. Mrs. Ed Roe Stamps, Macon, is Chairman this year and you may contact her if you have an entry.

GaMPAC

The Georgia Medical Political Action Committee will hold a Breakfast for the Board of Directors at the Macon Hilton Hotel, in the Wisteria Room on Friday, May 12.

Antique Car Show

Something is added each year and with Dr. Milton I. Johnson, Macon, an antique car buff himself, as Chairman of the Antique Car Show in May, there should be a great deal of interest shown in this activity. All physicians in Georgia who have antique cars and wish to display them at the meeting, please contact Milton I. Johnson, Jr., M.D., 2605 Cherokee Avenue, Macon, Georgia 31204. A covered, guarded display area will be provided in the Hilton Parking Garage. An experienced judge has been engaged

to judge all entered vehicles. Trophies will be awarded for the Best Car of The Show, Best Antique Car, Best Production Car (through 1942), and the Best Classic Car.

Scientific Exhibits

The Scientific Exhibits will be displayed in an area adjacent to the Commercial Exhibits at the Macon Hilton. These are prepared by physicians who will be present to discuss their exhibits with the membership. Awards for outstanding research will be presented at the Annual Banquet.

Commercial Exhibits

Approximately 35 Commercial Exhibits will be displayed in the Macon Hilton Hotel. The exhibit area has been floor-planned by the decorating company with the easy flow of traffic in mind. Your visitation to the Commercial Exhibits and the Scientific Exhibits is important and another handsome prize will be offered this year. The Commercial Exhibitors play an extremely important role in making the Annual Session possible through their support of the meeting and it is urged that you visit each exhibit.

Commercial Exhibitors

<i>Booth No.</i>	<i>Name of Firm</i>
1	A. H. Robins Company, Richmond, Virginia
2	Encyclopaedia Britannica, Inc., Chicago, Illinois

- 3 Life Insurance Company of Georgia, Atlanta, Georgia
- 4 Ayerst Laboratories, New York, New York
- 5 Smith, Miller & Patch, Inc., New Brunswick, New Jersey
- 11 Hill Crest Hospital, Birmingham, Alabama
- 12 BBC Health Care Industries, Inc., St. Louis, Missouri
- 13 Ortho Pharmaceutical Corporation, Raritan, New Jersey
- 14 Stuart Pharmaceuticals, Pasadena, California
- 15 G. D. Searle & Company, Chicago, Illinois
- 16 Wm. P. Poythress & Co., Inc., Richmond, Virginia
- 17 Mead Johnson Laboratories, Evansville, Indiana
- 18 Riker Laboratories, Inc., Northridge, California
- 23 Pitney-Bowes, Inc., Macon, Georgia
- 24 Blue Cross-Blue Shield, Columbus, Georgia
- 25 W. B. Saunders Company, Philadelphia, Pennsylvania
- 26 Security Life Insurance Company of Georgia, Macon, Georgia
- 27 Georgia Bank and Trust Company, Macon, Georgia
- 32 Pfizer Laboratories, Doraville, Georgia
- 33 Astra Pharmaceutical Products, Inc., Worcester, Massachusetts
- 34 Sandoz Pharmaceuticals, Hanover, New Jersey
- 35 Marshall Erdman and Associates, Inc., Atlanta, Georgia

Commercial Contributions

Eli Lilly and Company, Indianapolis, Indiana
Roche Laboratories, Nutley, New Jersey
Geigy Pharmaceuticals, Ardsley, New York

An educational support grant through the Merck Sharp and Dohme Postgraduate Program has been made to MAG.

CALL FOR SCIENTIFIC EXHIBITS*

118TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA
Macon, Georgia, May 11-14, 1972

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee
938 Peachtree Street, N.E. • Atlanta, Georgia 30309

* Space is limited at the Macon Hilton and requests for applications should be made early to establish priority.

...in the presence of spasm or hypermotility,
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- ☐ simethicone—for accompanying distension and pain due to gas
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nary bladder atony. Prolonged use of barbiturates may be habit-forming.

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(from the Greek *kinetikos*,
to move,
and the Latin *sedatus*,
to calm)

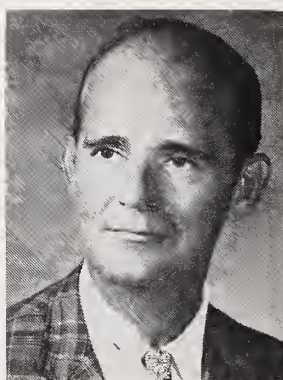
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antispasmodic/sedative/antiflatulent

Spring peeper (tree frog, *Hyla crucifer*):
this small amphibian can expand
its throat membrane with air until it is
twice the size of its head.

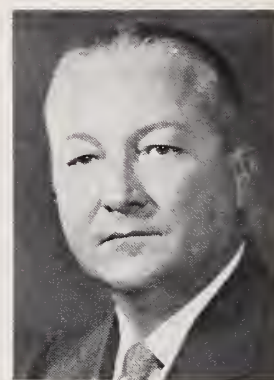
OFFICERS AND COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA



W. C. Mitchell
President



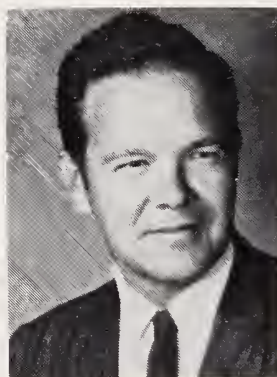
F. W. Dowda
President-Elect



Henry D. Scoggins
First Vice President



Braswell Collins
Second Vice President



John Rhodes Haverty
Secretary



C. E. Bohler
Chairman of Council

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Past President—John Kirk Train, Savannah (1973)
Past President—Charles R. Andrews, Jr., Canton (1972)
First Vice President—Henry D. Scoggins, Augusta (1972)*
Second Vice President—Braswell E. Collins, Macon (1972)*
Chairman of Council—C. E. Bohler, Brooklet (1972)*
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Treasurer—John S. Atwater, Atlanta (1972)
Speaker of the House—Harrison L. Rogers, Atlanta (1974)*
Vice Speaker of the House—Preston D. Ellington, Augusta (1974)
Editor, JMAG—Edgar Woody, Jr., Atlanta (1972)

COUNCILORS

District:

- 1—C. E. Bohler, Brooklet (1973)
- 2—J. D. Bateman, Albany (1973)
- 3—J. T. Christmas, Vienna (1973)
- 6—Norman P. Gardner, Thomaston (1974)
- 7—David A. Wells, Dalton (1974)*
- 8—Robert E. Perry, Jr., Brunswick (1974)
- 9—Paul T. Scoggins, Commerce (1972)
- 10—Edwin W. Allen, Jr., Milledgeville (1972)

Bibb County Medical Society
 Braswell E. Collins, Macon (1972)
 Cobb County Medical Society
 Remer Y. Clark, Marietta (1972)
 DeKalb County Medical Society
 M. Freeman Simmons, Decatur (1972)
 Fulton County Medical Society
 Fleming L. Jolley, Atlanta (1972)
 J. Harold Harrison, Atlanta (1973)
 John T. Godwin, Atlanta (1974)
 Georgia Medical Society
 L. R. Lanier, Jr., Savannah (1973)
 Muscogee County Medical Society
 Jack A. Raines, Columbus (1974)
 Richmond County Medical Society
 J. L. Mulherin, Augusta (1972)

* *Executive Committee*

VICE COUNCILORS

District:

- 1—Albert M. Deal, Statesboro (1973)
- 2—Donald J. McKenzie, Thomasville (1973)
- 3—John H. Robinson, Americus (1973)
- 6—W. E. Barron, Newnan (1974)
- 7—Don Schmidt, Cedartown (1974)
- 8—Joe C. Stubbs, Valdosta (1974)
- 9—Robert S. Tether, Gainesville (1972)
- 10—M. A. Hubert, Athens (1972)

Bibb County Medical Society
Milton I. Johnson, Macon (1972)
Cobb County Medical Society
Charles R. Underwood, Marietta (1972)
DeKalb County Medical Society
L. C. Buchanan, Decatur (1972)
Fulton County Medical Society
T. J. Anderson, Jr., Atlanta (1972)
W. W. Moore, Jr., Atlanta (1973)
J. Norman Berry, Sandy Springs (1974)
Georgia Medical Society
L. S. Bodziner, Savannah (1973)
Muscogee County Medical Society
Louis A. Hazouri, Columbus (1974)

Richmond County Medical Society
Ronald F. Galloway, Augusta (1972)
DELEGATES TO AMA AS OF JANUARY 1, 1972
Delegates *Term Ending*
J. W. Chambers, LaGrange (12-31-73)
John S. Atwater, Atlanta (12-31-73)
J. Frank Walker, Atlanta (12-31-72)
Preston D. Ellington, Augusta (12-31-72)
Alternate Delegates
F. G. Eldridge, Valdosta (12-31-73)
Henry S. Jennings, Gainesville (12-31-73)
J. D. Bateman, Albany (12-31-72)
F. W. Dowda, Atlanta (12-31-72)

MEDICAL ASSOCIATION OF GEORGIA PRESENTS
14th ANNUAL ART SHOW
GRAND FOYER, MACON HILTON HOTEL
MAY 11-14, 1972

Attention All Artists

Entries:

Each artist is limited to 3 entries. On the back of each place a 3" x 5" card with your name, address, title of exhibit and selling price. All entries must be ruled acceptable before being hung. Work must be original. Art work that has won previously will be excluded. Sales are encouraged with a 20 per cent commission charged to benefit AMA-ERF.

Categories:

(1) Paintings—Including Watercolor, Oil and Mixed Media, framed and ready for hanging.

- (2) Photography—Must be matted.
- (3) Sculpture
- (4) Arts and Crafts

Judge:

Judging for appropriate prizes will be done Saturday morning. No one will be allowed in the judging area at this time.
All entries must be brought to the Grand Foyer area between 10:00 a.m. and 5:00 p.m. on Thursday and Friday, May 11 and 12, and picked up on Sunday by noon following adjournment of the Annual Session. Security guards will be on duty at all times.

ART SHOW PRE-REGISTRATION CARD

Please fill this out and mail as soon as possible to:
Mrs. Ed Roe Stamps
645 Orange Street
Macon, Georgia 31201

Name
Address
City & State Zip

I plan to enter the following categories: (Indicate number of each)

(1) Paintings
(2) Photography
(3) Sculpture
(4) Arts and Crafts

ARTIST'S RECEIPT

NAME
ADDRESS
CITY & STATE ZIP

ENTRIES

1. Title
Price
2. Title
Price
3. Title
Price

Bring This Card With Your Entry!

REPRESENTATIVE'S SIGNATURE
PAINTINGS MUST BE PICKED UP BY SUNDAY
NOON, MAY 14, 1972.

OFFICIAL PROGRAM

THURSDAY, MAY 11

- 8:30 General and Delegates Registration**
Grand Foyer Entrance, Hilton
- 9:00 View Exhibits**
- 9:00 Specialty Society Meetings and Lunch-
to
eons**
- 5:00** *(See Specialty Society Meetings and Social
Events Section)*
- 6:30 Specialty Society Receptions and Din-
ners**
*(See Specialty Society Meetings and Social
Events Section)*

FRIDAY, MAY 12

- 8:00 General and Delegates Registration**
Grand Foyer Entrance, Hilton
- 8:30 View Exhibits**
- 9:00 First General Session**
Presiding
W. C. Mitchell, M.D., Smyrna, Presi-
dent, Medical Association of Georgia
Call to Order
Invocation
Rev. John E. Richards, First Presbyteri-
an Church, Macon
Presentation of Colors
R.O.T.C. Color Guard
Major Davis Carter, Commanding
Macon
"God Bless America"
Mrs. John Grenga, Soloist
Mr. Putnam Porter, Accompanist
Macon
Welcome
L. E. Dickey, Jr., M.D., Macon, Presi-
dent, Bibb County Medical Society
Greetings
Honorable Ronnie Thompson, Mayor,
City of Macon
Introduction of Distinguished Guests
**Report of President of Woman's Aux-
iliary**
Mrs. George W. Statham, Atlanta, Presi-
dent, Woman's Auxiliary to the Med-
ical Association of Georgia
**Greetings From the President of Wom-
an's Auxiliary to AMA**
Mrs. G. Prentiss Lee, Portland, Oregon

- Report From the Student American
Medical Association Chapter Presidents**
Mr. Joe Pilkington, President, Emory
University School of Medicine SAMA
Chapter, Atlanta
Mr. Charles L. Ogburn, Jr., President,
Medical College of Georgia SAMA
Chapter, Augusta
Special Program: "Charms of Macon"
Mrs. Jean Holmes, Manager, Macon
Tourist Information Center
President-Elect's Address
F. W. Dowda, M.D., Atlanta, President-
Elect, Medical Association of Georgia
Announcements
Recess

- 11:00 First Session, House of Delegates**
Harrison L. Rogers, M.D., Atlanta,
Speaker
**Nominations of Officers of MAG, AMA
Delegates and Alternates**
**Announcement of Family Physician of
the Year and Award Presentation**
Introduction of Business
Announcements
Recess
- 12:00 Special Program**
Presiding
W. C. Mitchell, M.D., Smyrna, Presi-
dent, Medical Association of Georgia
"Government Controlled Medical Care"
H. E. Godfrey, M.D., Manchester, En-
gland
- 12:30 View Exhibits**
- 2:00 General Meeting**
(All Physicians, Auxiliary Members and
Guests Invited)
Ballroom, Hilton
**"Health Care Delivery Systems in
U.S.A.—Past, Present and Future"**
Moderator
Braswell E. Collins, M.D., Macon, Sec-
ond Vice President, Medical Associa-
tion of Georgia
Panelists
Russell B. Roth, M.D., Erie, Pennsyl-
vania
Wesley W. Hall, Jr., M.D., Reno, Ne-
vada

Paul J. Sanazaro, M.D., Rockville, Maryland

5:00 View Exhibits

6:30 Alumni Receptions and Dinners
(See Alumni Events Section)

SATURDAY, MAY 13

8:00 General and Delegates Registration
Grand Foyer Entrance, Hilton

8:30 View Exhibits

9:00 Reference Committee Meetings
Hilton Hotel

2:00 General Meeting
(All Physicians, Auxiliary Members and Guests Invited)

Ballroom, Hilton

Moderator

Henry D. Scoggins, M.D., Augusta, First Vice President, Medical Association of Georgia

"Management of Syphilis and Gonorrhea"

William J. Brown, M.D., Atlanta

"Sex in Schools"

Melvin Anchell, M.D., Los Angeles, California

"Dynamics of Violence"

Jan Alan Fawcett, M.D., Chicago, Illinois

5:00 View Exhibits

6:30 Bibb County Medical Society Social Hour

(All MAG Members, Their Wives and Exhibitors Invited)

Elm-Mulberry Rooms, Hilton

8:00 Annual Banquet
Ballroom, Hilton

Presiding

W. C. Mitchell, M.D., Smyrna, President, Medical Association of Georgia

Presentation of Awards:

Special Activities Awards: Golf, Tennis, Art, Medical Mile and Antique Car

Scientific Exhibits Awards

Hardman Award

Civil Endeavor Award

Inauguration of President of the Medical Association of Georgia

Entertainment

SUNDAY, MAY 14

7:00 Prayer Breakfast
Elm-Cherry Rooms, Hilton

Presiding

W. H. Pool, M.D., Augusta

"Treatment of the Whole Patient"

Professor Charles R. Brewster, Macon

M. D. Pittard, M.D., Toccoa

8:00 General and Delegates Registration
Grand Foyer Entrance, Hilton

8:30 View Exhibits

9:00 Second General Session
(All MAG and Auxiliary Members and Guests Invited)

Ballroom, Hilton

Presiding

W. C. Mitchell, M.D., Smyrna, President, Medical Association of Georgia

Call to Order

Religious Observance

Rev. Frank K. Allan, Rector, St. Paul's Episcopal Church, Macon

Memorial Service

Rev. Frank K. Allan, Rector, St. Paul's Episcopal Church, Macon

Presentation of Certificates of Appreciation

John Rhodes Haverty, M.D., Atlanta, Secretary, Medical Association of Georgia

Presentation of Life Membership Certificates

Braswell E. Collins, M.D., Macon, Second Vice President, Medical Association of Georgia

Presentation of 50 Year Membership Certificates

Henry D. Scoggins, M.D., Augusta, First Vice President, Medical Association of Georgia

Presentation of Distinguished Service Award

W. C. Mitchell, M.D., Smyrna, President, Medical Association of Georgia

Announcement of Site for May 1978 and 1979 Annual Sessions

Recess

10:00 Second Session, House of Delegates
Presiding

Harrison L. Rogers, M.D., Atlanta, Speaker

Election of MAG Officers, AMA Delegates and Alternates
Reference Committee Reports
Announcements
Adjournment of House of Delegates

12:00 Second General Session (Reconvened)
Presiding

W. C. Mitchell, M.D., Smyrna, President, Medical Association of Georgia
Installation of Officers
Announcements
Commercial Exhibit Visitation Drawing
Adjournment of 118th Annual Session

SPECIALTY SOCIETY MEETINGS AND SOCIAL EVENTS

Specialty Society Program Chairmen

GEORGIA SOCIETY OF ANESTHESIOLOGISTS

H. T. Bloodworth, M.D., 781 Spring St., Macon, 31201

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS AND GEORGIA THORACIC SOCIETY

G. Michael Duffell, M.D., Emory University School of Medicine, 1365 Clifton Road, N.E., Atlanta, 30322

GEORGIA TB-RD ASSOCIATION

Mr. Flay Sellers, Administrative Assistant, 1383 Spring St., N.W., Atlanta, 30309

GEORGIA SOCIETY OF DERMATOLOGISTS

Beverly B. Sanders, Jr., M.D., 700 Spring St., Macon, 31201

GEORGIA DIABETES ASSOCIATION

Harold C. Atkinson, M.D., 724 Hemlock St., Macon, 31201

GEORGIA SOCIETY OF INTERNAL MEDICINE

Charles Hollis, M.D., 910 N. Jefferson St., Albany, 31705

GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Henry H. Tift, M.D., 765 Spring St., Macon, 31201

GEORGIA NEUROSURGICAL SOCIETY

Robert A. Clark, Jr., M.D., 755 Orange Terrace, Macon, 31201

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY

John D. Thompson, M.D., 789 Houston Mill Rd., N.E., Atlanta

Mr. Chester Lane, 69 Butler St., S.E., Atlanta 30303, Executive Secretary

GEORGIA SOCIETY OF OPHTHALMOLOGY

William H. Jarrett, M.D., 575 W. Peachtree St., N.E., Atlanta, 30308

John H. Reed, M.D., 1128 Vine St., Gainesville, 30501

GEORGIA ORTHOPEDIC SOCIETY

Toni Fernandez, M.D., Orthopedic Associates, 870 High Street, Macon, 31201

GEORGIA SOCIETY OF OTOLARYNGOLOGY

John S. Turner, M.D., 1355 Clifton Rd., N.E., Atlanta, 30322

GEORGIA ASSOCIATION OF PATHOLOGISTS

John G. Etheridge, M.D., 777 Hemlock St., Macon, 31201

GEORGIA PSYCHIATRIC ASSOCIATION

Z. Sweeney Sikes, M.D., 803 Spring St., Macon, 31201

GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

Robert J. Walker, Jr., M.D., 770 Hemlock St., Macon, 31201

GEORGIA RADIOLOGICAL SOCIETY

W. H. Somers, M.D., Department of Radiology, Macon General Hospital, Macon, 31201

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Charles H. Richardson, Jr., M.D., 724 Hemlock St., Macon, 31201

**GEORGIA SOCIETY OF
ANESTHESIOLOGISTS**

Saturday, May 13

- 2:00 Scientific and Business Meeting
Jasmine Room, Hilton
Presiding: Thomas L. Tidmore, Jr., M.D., Atlanta
John Adriani, M.D., New Orleans, Louisiana: "Drug Interactions and Incompatibilities in Anesthesiology"

Sunday, May 14

- 9:00 Scientific and Business Meeting
Jasmine Room, Hilton
Presiding: Thomas L. Tidmore, Jr., M.D., Atlanta
John Adriani, M.D., New Orleans, Louisiana: "The Toxicity and Lack of Toxicity of Halogenated Compounds Used in Anesthesiology"

**GEORGIA CHAPTER, AMERICAN COLLEGE
OF CHEST PHYSICIANS, GEORGIA
THORACIC SOCIETY AND GEORGIA
TUBERCULOSIS-RESPIRATORY DISEASE
ASSOCIATION**

Thursday, May 11

- 9:00 Scientific Meeting
Walnut & Mulberry Rooms, Hilton
Presiding: James K. Van Buren, M.D., Atlanta
Dr. Lee Hand, Atlanta, Georgia: "Pulmonary Defense Mechanisms" and "The Importance of Nosocomial Infections in Pulmonary Disease"; Dr. James Raleigh, Houston, Texas: "Current Management of Tuberculosis" and "Current Concepts of Infectivity," "Isolation Techniques," "Pathogenesis."

- 12:00 Luncheon
Wisteria Room, Hilton

- 2:00 Scientific Meeting
Walnut & Mulberry Rooms, Hilton
Presiding: James K. Van Buren, M.D., Atlanta
(Speaker to Be Announced): "Diagnostic Approach to Patients With Pulmonary Fungus Infections"; (Speaker to Be Announced): "The Therapeutic Approach to Fungus Infections of the Lungs"; Dr. James Crutcher, Atlanta, Georgia: "Diagnosis and Treatment of Bacterial Pneumonias" and "Evaluation and Treatment of Patients With Chronic Bronchitis."

- 6:00 Social Hour
Walnut Room, Hilton

GEORGIA SOCIETY OF DERMATOLOGISTS

Friday, May 12

- 9:00 Business Meeting
Elm Room, Hilton

- 7:00 Social Hour
Magnolia Room, Hilton
8:00 Dinner
Cherokee Rose Room, Hilton

Saturday, May 13

- 9:00 Scientific Meeting
Cherokee Rose Room, Hilton
12:00 Luncheon
Walnut Room, Hilton
6:30 Social Hour
Cherokee Rose Room, Hilton

Sunday, May 14

- 9:00 Case Presentation
Cherokee Rose Room, Hilton
1:00 Luncheon
Walnut & Mulberry Rooms, Hilton

GEORGIA DIABETES ASSOCIATION

Thursday, May 11

- 3:30 Business Meeting
Camellia Room, Hilton
Presiding: A. Park McGinty, M.D., Atlanta

**GEORGIA SOCIETY OF INTERNAL
MEDICINE**

Thursday, May 11

- 4:30 Business Meeting
Wisteria Room, Hilton
Presiding: Luther G. Fortson, Jr., M.D., Marietta

**GEORGIA CHAPTER, AMERICAN COLLEGE
OF PHYSICIANS**

Thursday, May 11

- 6:00 Business Meeting
Wisteria Room, Hilton
Presiding: W. J. O'Shaughnessey, M.D., Macon

GEORGIA NEUROSURGICAL SOCIETY

Sunday, May 14

- 12:00 Social Hour
Azalea Room, Hilton
Presiding: W. Upton Clary, M.D., Savannah
1:00 Luncheon
Camellia Room, Hilton
2:00 Scientific Meeting
Wisteria Room, Hilton
Presiding: W. Upton Clary, M.D., Savannah

**GEORGIA STATE OBSTETRICAL AND
GYNECOLOGICAL SOCIETY**

Thursday, May 11

- 8:30 Coffee
Elm and Cherry Rooms, Hilton
Presiding: John D. Thompson, M.D. Atlanta
9:30 Scientific Meeting
Elm and Cherry Rooms, Hilton

Presiding: John D. Thompson, M.D., Atlanta
 Dr. Henry Thiede, Jackson, Mississippi:
 "Obstetrics in Mississippi—an Overview."

10:30 Coffee and Cokes
Elm and Cherry Rooms, Hilton

11:00 Scientific Meeting
Elm and Cherry Rooms, Hilton

Presiding: John D. Thompson, M.D. Atlanta
 Dr. Richard Boronow, Jackson, Mississippi:
 "The Complicated Vaginal Fistula"; Dr.
 George Huggins, Jackson, Mississippi:
 "Laparoscopy and Tubal Fulguration."

12:00 Luncheon and Business Meeting
Cherokee Rose Room, Hilton

2:30 Scientific Meeting
Elm and Cherry Rooms, Hilton

Presiding: John D. Thompson, M.D., Atlanta
 Dr. Richard Boronow, Jackson, Mississippi:
 "Progress in Cervical Cancer"; Dr. Donald
 Sherline, Jackson, Mississippi: "Intra-
 Uterine Diagnosis in Pregnancy"; and
 Questions and Answers with entire panel
 participating.

5:00 Cocktail Buffet
Wesleyan Room, Hilton

GEORGIA SOCIETY OF OPHTHALMOLOGY AND GEORGIA SOCIETY OF OTOLARYNGOLOGY

Saturday, May 13

1:00 Luncheon and Business Meeting
Magnolia Room, Hilton

Presiding: John H. Reed, M.D., Gainesville
 and John S. Turner, M.D., Atlanta
 Dr. F. William Dowda, Atlanta, Georgia:
 "The Influence of Medical Foundations on
 Specialty Practice."

GEORGIA ORTHOPEDIC SOCIETY

Thursday, May 11

10:00 Scientific Meeting and Luncheon
Azalea Room, Hilton
 Presiding: A. S. Carswell, M.D., Augusta

GEORGIA ASSOCIATION OF PATHOLOGISTS

Thursday, May 11

1:00 Business Meeting
Jasmine Room, Hilton
 Presiding: Robert E. DeLashmutt, M.D., At-
 lanta
 6:30 Reception and Dinner
Cherokee Rose Room, Hilton

GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS AND GEORGIA PSYCHIATRIC ASSOCIATION

Thursday, May 11

2:00 Scientific Meeting
Mulberry Room, Hilton

Presiding: Z. Sweeney Sikes, M.D., Macon
 and R. J. Walker, Jr., M.D., Macon
 Dr. Robert L. DuPont, Washington, D.C.:
 "Multi-Modality Approach to Drug Treat-
 ment for the Nation"; Dr. Peter G.
 Bourne, Atlanta, Georgia: "Development
 of a Statewide Narcotic Treatment Pro-
 gram for Georgia."

3:25 Panel

Moderator: Chaplain C. Earl Davis, Coordi-
 nator of Macon-Bibb County Health De-
 partment, Macon
 Four Drug Counselors from Drug Rehabilita-
 tion Center, Macon-Bibb County Health
 Department

GEORGIA RADIOLOGICAL SOCIETY

Saturday, May 13

10:00 Business and Scientific Meeting
Elm Room, Hilton

Presiding: W. H. Somers, M.D., Macon

12:00 Luncheon
Cherry Room, Hilton

6:30 Social Hour and Dinner
 (Location to Be Decided by Chairman)

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Thursday, May 11

9:30 Scientific Meeting
Jasmine Room, Hilton

Presiding: Charles E. Todd, Jr., M.D., At-
 lanta
 Dr. W. Dean Warren, Atlanta: "Surgical
 Treatment of Pancreatitis"; (Speaker and
 Title to Be Announced); Dr. William
 H. Moretz, Augusta, Georgia: "Thrombo-
 Embolic Disease"; Dr. Robert A. Parrish,
 Jr., Augusta, Georgia: "Recent Develop-
 ments in Pediatric Surgery"; Panel on
 "Trauma" with case presentation: Above
 guest speakers and Dr. Carl Jelenko, III,
 Augusta, Georgia.

12:00 Reception and Luncheon
Magnolia Room, Hilton

ALUMNI EVENTS

MEDICAL COLLEGE OF GEORGIA ALUMNI

Friday, May 12

6:30 Reception and Dinner
Idle Hour Country Club
 President: Don Schmidt, M.D., Cedartown

EMORY UNIVERSITY SCHOOL OF MEDICINE ALUMNI

Friday, May 12

6:30 Reception and Dinner
Hilton Hotel
 Chairman: Edmund A. Brannen, M.D., Ma-
 con

TULANE UNIVERSITY MEDICAL ALUMNI

Friday, May 12

7:00 Reception
Jasmine Room, Hilton

MEDICAL COLLEGE OF GEORGIA CLASS OF 1947—25TH REUNION

Friday, May 12

6:30 Reception and Dinner
Idle Hour Country Club, Macon
Chairman: W. A. Dodd, M.D., Wrightsville

OTHER EVENTS

GEORGIA MEDICAL POLITICAL ACTION COMMITTEE BOARD OF DIRECTORS MEETING

Friday, May 12

7:30 Breakfast and Meeting
Wisteria Room, Hilton

MEDICAL COLLEGE OF GEORGIA FOUNDATION, INC.

Saturday, May 13

12:00 Luncheon
Dogwood Room, Hilton

PRAYER BREAKFAST SPONSORED BY MAG COMMITTEE ON MEDICINE AND RELIGION

Sunday, May 14

7:00 Prayer Breakfast
Elm-Cherry Rooms, Hilton

CRITERIA FOR SELECTION OF RECIPIENTS OF MAG AWARDS

FAMILY PHYSICIAN OF THE YEAR (formerly GP OF THE YEAR)—This award is presented to an outstanding Family Physician in Georgia. Selection of the recipient will be made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award will be made during the first session of the House. The name of the Family Physician, accompanied by supporting biographical data, should be received at the MAG Headquarters Office by February 15 for inclusion in the Delegates Handbook. No nominations for this award may be made from the floor of the House. The President of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award at the First Session of the House.

HARDMAN CUP—This award is presented for "the achievement of anyone who, in the judgment of the Association, has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented at the Annual Banquet, Saturday evening, May 13. By custom this award has usually gone to a Georgia physician. However, this is not required by the terms of the letter

from Governor Hardman establishing this award.

DISTINGUISHED SERVICE—The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Sunday, May 14, 9:00 a.m., at the final General Session.

CERTIFICATE OF APPRECIATION—Recipients of Certificates of Appreciation will be selected jointly by the MAG Committee on Awards, Executive Committee and Council. These will be presented on Sunday, May 14, at 9:00 a.m., at the final General Session.

CIVIC ENDEAVOR AWARD—This is a new award, presented for the first time at the 1969 Annual Session, and will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters Office at least two weeks in advance of the Annual Session. The recipient of this award will be selected by a three-man secret committee, who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at the Annual Banquet, Saturday evening, May 13.

Woman's Auxiliary to the Medical Association of Georgia 47th Annual Convention



PRESIDENT'S GREETING

AS YOUR PRESIDENT, I am delighted to welcome each one of you to our 47th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Macon is a city of hospitality, and the Bibb County Medical Auxiliary has worked tirelessly to make this convention a Season of Hospitality, Southern Style.

It is my sincere desire that together we will experience the joys of accomplishment and fellowship in our past year's efforts to "Accelerate Awareness into Action."

Sincerely,
Mrs. George W. Statham, *President*
Woman's Auxiliary to the
Medical Association of Georgia



WELCOME TO MACON

THE WOMAN'S AUXILIARY to the Bibb County Medical Society considers it a real privilege and pleasure to be the hostess for the 47th Annual Convention for the Woman's Auxiliary to the Medical Association of Georgia.

We have anticipated your visit with much enthusiasm and with many months of planning. We hope you will join in the social as well as the business activities. If anyone desires more information about Middle Georgia facilities, resources, or historical points, please contact me and I will be glad to give you any aid or assistance I can.

We are very proud of our "Heart of Georgia" city and hope Macon will not be too big for the "Country Doctor" or too small for the "City Slicker."

Y'all come,
Mrs. Richard L. Hanberry, *President*
Woman's Auxiliary to the
Bibb County Medical Society

THE PROGRAM

THURSDAY, MAY 11

9:00 Registration and Information

to Lobby

5:00 Hilton Hotel

10:00 Hospitality and Exhibits

to Lobby Lounge

5:00 Hilton Hotel

2:00 Pre-Convention Executive Board to Meeting

4:00 Magnolia Room

Hilton Hotel

PRESIDING—MRS. GEORGE W. STATHAM, Atlanta, *President, Woman's Auxiliary to the Medical Association of Georgia*

INVOCATION—MRS. PAUL T. SCOGGINS, Commerce, *Ninth District Councilor and President, Jackson-Banks Medical Auxiliary*

PLEDGE OF LOYALTY AND COLLECT—MRS. MAXWELL J. SWEAT, JR., Albany, *State Chairman, Home-Centered Health Care*

INTRODUCTION OF PAST PRESIDENTS—MRS. A. WORTH HOBBY, Atlanta, *Past President*

4:00 Adjournment

4:30 Social Hour for 1972-73 County Presidents and Presidents-Elect

Penthouse Parlor, Number 1716

Hilton Hotel

FRIDAY, MAY 12

8:00 Registration and Information

to Lobby

5:00 Hilton Hotel

8:00 Hospitality and Exhibits

to Lobby Lounge

5:00 Hilton Hotel

9:00 MAG First General Session

to Ballroom

10:00 Hilton Hotel

(All MAG and Auxiliary Members and
Guests Invited)

PRESIDING—W. C. MITCHELL, M.D.,
Smyrna, *President*

REPORT OF WOMAN'S AUXILIARY
TO MAG—MRS. GEORGE W. STATHAM,
Atlanta, *President*

GREETINGS FROM THE WOMAN'S
AUXILIARY TO AMA—MRS.
G. PRENTISS LEE, Portland, Oregon,
President

10:30 Auxiliary General Meeting

to Ballroom

12:00 Idle Hour Country Club

10:30 Call to Order

MRS. GEORGE W. STATHAM, Atlanta,
President

INVOCATION—MRS. W. P. RHYNE, Albany, *Past President*

PLEDGE OF ALLEGIANCE TO FLAG
—MRS. D. R. MAHAN, JR., Rocky Face,
*President, Whitfield-Murray County
Medical Auxiliary*

PLEDGE OF LOYALTY AND COLLECT—MRS. CHARLES E. FINNEY,
LEESBURG, *President, Dougherty County
Medical Auxiliary*

ADDRESS OF WELCOME—MRS. RICHARD L. HANBERRY, JR., Macon, *President, Bibb County Medical Auxiliary*

RESPONSE TO WELCOME—MRS. LUTHER B. OTKEN, Augusta, *President, Richmond County Medical Auxiliary*

PRESENTATION OF CONVENTION
PLANS—MRS. RALPH G. NEWTON, JR.,
Macon, *Convention Chairman*

INTRODUCTION OF PAGES FOR THE
DAY—MRS. CHARLES DUGGAN, Macon

INTRODUCTION OF PAST PRESIDENTS AND GUESTS—MRS. JAMES H. MANNING, Marietta, *Past President, Vice Councilor to Southern Medical Auxiliary*

GREETINGS

PRESIDENT OF MAG—W. C. MITCHELL, M.D., Smyrna

PRESIDENT-ELECT OF MAG—F. W. DOWDA, M.D., Atlanta

Introduction of Guest Speaker

MRS. JOHN G. BATES, Cuthbert, *First Vice President*

ADDRESS—MRS. G. PRENTISS LEE, Portland, Oregon, *President, Woman's Auxiliary to AMA*

Business Session

(All reports limited to two minutes)

CONVENTION RULES OF ORDER—

MRS. S. WILLIAM CLARK, JR., Waycross, *Parliamentarian and Past President*

ROLL CALL AND MINUTES—MRS.

MILTON F. BRYANT, Atlanta, *Recording Secretary*

TREASURER'S REPORT—(Including

Auditor's Report)—MRS. GEORGE HARRISON, Marietta, *Treasurer*

REPORT OF ADVISORY COMMITTEE

**TO THE WOMAN'S AUXILIARY TO
MAG—F. G. ELDRIDGE, M.D., Val-**
dosta, Chairman

PRESIDENT'S REPORT—MRS. GEORGE

W. STATHAM, Atlanta

PRESIDENT-ELECT'S REPORT—MRS.

CLIFF MOORE, JR., Rome

ADDENDUM REPORTS—State Officers

*and Chairmen (Complete reports are
published in the 1971-72 Annual Re-*
port Book)

RECOMMENDATIONS FROM THE

**EXECUTIVE BOARD—MRS. MILTON
F. BRYANT, Atlanta**

REPORT OF REVISION COMMITTEE

—MRS. LOUIE H. GRIFFIN, Claxton,
Chairman

REPORT OF THE CREDENTIALS

COMMITTEE—MRS. BENJAMIN BASH-
INSKI, JR., Macon

ANNOUNCEMENTS

12:00 Recess of Session

12:00 Hospitality Hour

Formal Parlor

Idle Hour Country Club

HONORING—MRS. G. PRENTISS LEE,

*President, Woman's Auxiliary to the
AMA and MRS. CHRISTOPHER MCCON-*
NELL, Atlanta, President, Woman's Aux-
iliary to SAMA

1:00 Luncheon and Fashion Show

Ballroom

Idle Hour Country Club

PRESIDING—MRS. GEORGE W. STAT-

HAM, Atlanta, President

INVOCATION—MRS. JOHN T. LESLIE,

Avondale Estates, Past President

INTRODUCTION OF PAST PRESI-

DENTS AND GUESTS—MRS. RALPH

H. CHANEY, Augusta, Past President

2:15 Tour and Tea

to Transportation from Idle Hour Country
5:00 Club

Evening

6:30 Alumni Receptions and Dinners and to Other Alumni Functions

9:00 (See MAG Program)

SATURDAY, MAY 13

8:00 Registration and Information

to Lobby

5:00 Hilton Hotel

8:00 Past Presidents' Breakfast (Dutch)

Hilton Hotel

Penthouse Parlor, Number 1716

PRESIDING—MRS. CHARLES R. SMITH,

Columbus, Past President

8:00 Hospitality and Exhibits Room

to Lobby Lounge

5:00 Hilton Hotel

9:30 Auxiliary General Meeting

to Ballroom

12:30 Idle Hour Country Club

Call to Order

MRS. GEORGE W. STATHAM, Atlanta,
President

INVOCATION—MRS. DAVID E. TANNER,

*Savannah, President, Georgia Medical
Auxiliary*

PLEDGE OF ALLEGIANCE TO FLAG

—MRS. OHLEN R. WILSON, Alma,
President, Ware County Medical Anx-
iliary

PLEDGE OF LOYALTY AND COL-

LECT—MRS. GARLAND P. BENNETT,
*JR., Atlanta, President, DeKalb County
Medical Auxiliary*

MEMORIAL SERVICE—MRS. MILFORD

B. HATCHER, Macon

INTRODUCTION OF PAGES FOR THE

DAY—MRS. CHARLES DUGGAN, Macon

INTRODUCTION OF PAST PRESI-

**DENTS AND GUESTS—MRS. JOHN
MEIER, Albany, Past President**

CONVENTION ANNOUNCEMENTS—

MRS. THEODORE ATKINSON, Macon,
Convention Co-Chairman



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

and Efudex® (fluorouracil) 5% cream can resolve it.

all it actinic, solar or senile keratoses,
many regard it as "precancerous."^{1,2}

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,^{3,4} offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these multiple lesions.

Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.⁵ Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.⁶

Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.⁵ The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.⁶

How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

References: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T., and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis*, 6:293, 1970. 4. Sams, W. M.: *Arch. Derm.*, 97:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer*, 25:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

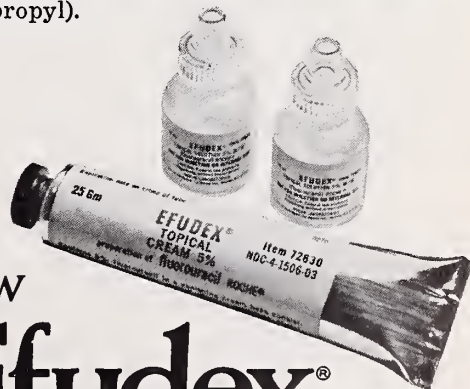
Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



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Efudex®
(fluorouracil)
cream/solution

Introduction of Guest Speaker

MRS. PERRY M. WHITE, Atlanta, *Councilor to Southern Medical Auxiliary*

ADDRESS—MRS. RAYMOND E. JONES, Louisville, Kentucky, *President, Woman's Auxiliary to the Southern Medical Association*

Business Session

READING OF MINUTES—MRS. MILTON F. BRYANT, Atlanta, *Recording Secretary*

REPORT OF THE REVISION COMMITTEE—MRS. LOUIE H. GRIFFIN, Claxton, *Chairman*

REPORT OF THE BUDGET AND FINANCE COMMITTEE—MRS. JAMES C. ROPER, Jasper, *Chairman*

REPORT OF THE RESOLUTIONS COMMITTEE—MRS. FRED O. KESSLER, JR., Savannah, *Chairman, First District Councilor*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. BENJAMIN BASHINSKI, JR., Macon, *Chairman*

REPORT OF COURTESY COMMITTEE—MRS. JOHN M. ANDERSON, Atlanta, *President, Medical Association of Atlanta Auxiliary*

REPORT OF THE AWARDS COMMITTEES

Achievement Award—MRS. MILTON B. SATCHER, JR., Atlanta, *Chairman*

AMA-ERF Awards—MRS. JAMES H. SULLIVAN, Columbus, *Chairman*

Doctor's Day Awards—MRS. CHARLES M. WARD, Dawson, *Chairman*

Health Careers Awards—MRS. DAVID L. MORGAN, Decatur, *Chairman*

Marie S. Burns Safety Award—MRS. ROBERT M. FINE, Atlanta, *Chairman*

Mrs. James Bonner White Scrapbook Awards—MRS. HENRY D. SCOGGINS, Augusta, *Chairman*

James N. Brawner, Sr., M.D. Awards for Excellence—MRS. CHARLES R. SMITH, Atlanta, *Chairman*

(Winners of Awards will please remain in Ballroom after Adjournment for official photographs)

REPORT OF MAG CONVENTION—PRESTON D. ELLINGTON, M.D., Augusta, *Chairman, MAG Annual Sessions Committee*

REPORT FROM SOUTHERN MEDICAL AUXILIARY—MRS. PERRY M. WHITE, Atlanta, *Councilor*

REPORT OF NOMINATING COMMITTEE—MRS. CHARLES R. SMITH, Atlanta, *Chairman*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—MRS. G. PRENTISS LEE, Portland, Oregon, *President, Woman's Auxiliary to AMA*

INAUGURAL ADDRESS AND ANNOUNCEMENTS OF 1972-73 STATE CHAIRMEN—MRS. CLIFF MOORE, JR., Rome, *President*

PRESENTATION OF PAST PRESIDENT'S PIN—MRS. CHARLES R. SMITH, Atlanta

ANNOUNCEMENTS

12:30 Adjournment

12:30 Hospitality Hour

Formal Parlor

Idle Hour Country Club

HONORING—MRS. CLIFF MOORE, JR., Rome, *President, Woman's Auxiliary to MAG*

MRS. RAYMOND E. JONES, Louisville, Kentucky, *President, Woman's Auxiliary to the Southern Medical Association*

1:00 Luncheon

to *Ballroom*

2:00 *Idle Hour Country Club*

PRESIDING—MRS. CLIFF MOORE, JR., Rome, *President*

INVOCATION—MRS. LOUIE H. GRIFFIN, Claxton, *Past President*

ENTERTAINMENT BY "THE SAFETASTICKS"

2:00 Suggested Activity

to **MAG General Meeting**

5:00 *Ballroom*

Hilton Hotel

"MANAGEMENT OF SYPHILIS AND GONORRHEA"—WILLIAM J. BROWN, M.D., Atlanta

"SEX IN SCHOOLS"—MELVIN ANCHELL, M.D., Los Angeles, California

"DYNAMICS OF VIOLENCE"—JAN ALAN FAWCETT, M.D., Chicago, Illinois

4:30 Social Hour for 1971-72 and 1972-73 State Chairmen

Penthouse Parlor, Number 1716

Hilton Hotel

PRESIDING—MRS. CLIFF MOORE, JR., Rome, *President*

6:30 Bibb County Medical Society Social Hour
(All MAG Members, Their Wives, and Exhibitors Invited)
Elm-Mulberry Rooms
Hilton Hotel

8:00 Annual Banquet
Ballroom
Hilton Hotel

SUNDAY, MAY 14

7:00 MAG Prayer Breakfast
to Elm-Cherry Rooms
8:00 Hilton Hotel
(Auxiliary members invited)

8:00 Registration and Information
to Lobby
12:00 Hilton Hotel

8:00 Hospitality and Exhibits
to Lobby Lounge
12:00 Hilton Hotel

9:00 Post-Convention Executive Board
to Breakfast and School of Instruction
12:00 Coliseum Park Hospital
Macon

PRESIDING—MRS. CLIFF MOORE, JR.,
Rome, President
INVOCATION—MRS. J. M. WALDREP,
Rome

9:00 MAG Final General Session
to Ballroom
12:00 Hilton Hotel
(All MAG and Auxiliary Members and Guests Invited)

PRESENTATION OF AWARDS
ELECTION AND INSTALLATION OF OFFICERS

**WOMAN’S AUXILIARY
TO THE
MEDICAL ASSOCIATION OF
GEORGIA—1971-1972**

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945 Milledge Road, Augusta, Georgia 30904
Third Vice-President MRS. PERRY M. WHITE
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Recording Secretary MRS. MILTON F. BRYANT
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1409 Satilla Boulevard, Waycross, Georgia 31501

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4079 Indian Lake Circle, Stone Mountain, Georgia 30083
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International Health MRS. J. M. WALDREP
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Home-Centered Health Care MRS. STANLEY P. ALDRIDGE
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Mental Health MRS. RUSSELL E. ANDREWS, JR.
Route 6, Kingston Road, Rome, Georgia 30161
Rural Health MRS. EMORY W. HOLLOWAY, JR.
180 Parkview Drive, Commerce, Georgia 30529

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2025 Breckenridge Drive, N.E., Atlanta, Georgia 30329
Achievement Awards MRS. MILTON B. SATCHER, JR.
1171 West Paces Ferry Road, N.W., Atlanta, Georgia 30327
James N. Brawner, Sr., M.D., Trophy MRS. CHARLES R. SMITH
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Doctor's Day	MRS. CHARLES M. WARD Box 203, Dawson, Georgia 31742
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Program Development	MRS. CLIFF MOORE, JR. 115 Saddle Mountain Road, Rome, Georgia 30161
Research and Romance of Medicine	MRS. HORACE H. OSBORNE 3609 Nassau Drive, Augusta, Georgia 30904
William R. Dancy, M.D. Student Loan Fund	MRS. WILLIAM N. AGOSTAS 2302 Overton Road, Augusta, Georgia 30904
William R. Dancy, M.D., Student Loan Fund (Co-chairman)	MRS. HARRY B. O'REAR 3069 Hillsdale Drive, Augusta, Georgia 30904
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WA-SAMA Liaison (Co-chairman)	MRS. ZACHARY M. KILPATRICK 2706 Hill Crest Avenue, Augusta, Georgia 30904
GaMPAC Representative	MRS. LUTHER M. VINTON, JR. 1043 Lakeshore Drive, Avondale Estates, Georgia 30002

Councilor to Southern Medical Association

MRS. PERRY M. WHITE
1547 Cave Road, N.W., Atlanta, Georgia 30327

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Mrs. Ralph H. Chaney, Augusta

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Worth President, Mrs. Frederick L. McLean
407 N. McPhaul Street, Sylvester, Georgia 31791
President-Elect—(None)

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Mrs. A. H. S. Weaver, Macon
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Mrs. Dan C. Newberry, Columbus
Mrs. Russell E. Andrews, Jr., Rome

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Hospitality
Mrs. William O. Williams, Jr., Macon
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Mrs. Charles Duggan, Macon
Pages for Medical Association
Mrs. John G. Etheridge, Macon
Finance
Mrs. Robert Cato, Macon

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Publicity
Mrs. Milton Johnson, Macon
Specialty Committee
Mrs. John O. Martin, Macon
Friday Luncheon
Mrs. J. T. Hogan, Jr., Macon
Saturday Luncheon
Mrs. Joe W. Daniel, Jr., Macon
Past Presidents' Breakfast
Mrs. J. R. S. Mays, Macon
President's Banquet
Charlottee S. Neuberg, M.D., Macon
Flowers for President's Banquet
Mrs. Ferdinand Kay, Macon
Tour and Transportation
Mrs. Hugh Smisson, Macon

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

MAG PLANS PHYSICIANS' ANTIQUE AUTOMOBILE SHOW AT MAY ANNUAL MEETING

Trophies to Be Awarded Best Cars

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Renal Osteodystrophy

ALBERT A. CARR, M.D.,* B. R. SHARPTON, M.D., ROBERT E. DICKS, B.S. and
T. E. TEMPLE, JR., M.D., *Augusta*

ALBERT A. CARR, M.D.: The clinical course of the two patients in this report is an example of the abnormalities in calcium and bone metabolism caused by renal excretory failure. This abnormality referred to as renal osteodystrophy will be reviewed in terms of histochemical and x-ray changes and the clinical manifestations. Finally, mechanisms related to the genesis of the bone disease will be discussed in an attempt to arrive at a reasonable approach to therapy.

B. R. SHARPTON, M.D.: ED, ETMH #112-724, a 13-year-old Negro female who was a patient on the pediatric service at the Eugene Talmadge Memorial Hospital was admitted for the evaluation of anemia, headache, and hearing loss. Approximately two weeks prior to admission she complained of headache, abdominal pain and was taken to the referring physician. Anemia was recognized and a history of chalk and starch ingestion was obtained. There was history of beginning thelarche but no menarche. When seen in the clinic here her hematocrit was 16 per cent, and the smear showed hypochromic microcytic red cells. The white count was normal except for eosinophilia. Platelet and reticulocyte counts were 175,000 and 2.5 per cent respectively. There was 3+ protein on urinalysis and the serum creatinine was 16.8 mg per cent. The serum uric acid was 9.2 mg per cent and the serum calcium and phosphorus were 4.4 and 11.4 mg per cent respectively. The serum protein electrophoresis was normal except for minimally elevated heterogeneous band of gamma globulin. There was no family history of renal disease, anemia, or hearing deficit.

Physical examination: Blood pressure was 130/75, pulse 80 per minute, respirations 24, oral temperature 37°C. She was in general a well-developed, fairly well-nourished, partially deaf Negro female. She was in the 25th percentile for weight and height.

Head, eyes, nose and throat were unremarkable except for bilateral hearing loss to both air and bone conduction. Neck was supple without masses. The chest was symmetrical. The breasts were undeveloped. The lungs were normal. Her heart was moderately enlarged. A Grade II/VI nonradiating systolic murmur was audible at the left sternal border. The abdomen was normal and the external genitalia was normal except there was no evidence of puberty, other than minimal pubic hair. The extremities were symmetrical with normal pulses and there was no edema. Pallor of the mucous membranes was present. Except for the hearing deficit neurological examination was normal.

Laboratory Data

Admission blood count was unchanged from the findings recorded in the clinic visit. The direct Coombs' test was negative. Serum iron and iron binding capacity, bilirubin and prothrombin time were normal and multiple stools for blood were negative. There were no sickled red cells. There was no evidence for a glucose-6-phosphate dehydrogenase (G-6-PD) deficiency. Urine specific gravity was 1.008 with a trace of glucose, 2+ protein, pH 5, 20-30 RBC/hpf and 10-20 WBC/hpf on microscopic examination. The creatinine clearance was 2.4 ml/minute and 24 hour urine protein was 1.6 gms. The serum alkaline phosphatase was elevated at 26.5 KA units. Multiple LE preparations were negative. The initial ASO titer was 833 Todd units. Serum complement was reduced to a titer of 1:16 initially but was subsequently normal at 1:32. The cultures of the urine grew no significant bacterial colonies. Table I depicts other significant chemical data. There was x-ray evidence for cardiomegaly and skeletal changes consistent with renal osteodystrophy. Figure 1 demonstrates the absence of distal tip of clavicle and widened-frayed diaphyseal proximal end of the humerus. The frayed and widened diaphysis are consistent with osteomalacia. Subperiosteal resorption

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FIGURE 1

of the phalanges was demonstrated on hand x-rays. These findings in addition to the loss of the distal tip of the clavicle are consistent with bone changes due to hyperparathyroidism. No bone changes could be detected on skull x-rays. Figure 2 demonstrates increased bone density of the dorsal vertebra consistent with osteosclerosis. Both kidneys were small as demonstrated by tomograms. Interstitial inflammation, edema, fibrosis, tubular atrophy and some glomerular obliteration was seen on renal biopsy. Bilateral nerve deafness was demonstrated by audiograms.

Hospital Course: Table I shows the major therapeutic manipulations. On admission and throughout the hospitalization the patient was active, out of bed and well adapted to her uremia and anemia. Except for short intervals immediately following renal biopsy, during and after peritoneal dialysis, she played consistently. There were differences of opinion as to the interpretation of the renal biopsy; glomerulonephritis versus interstitial nephritis. The increased ASO titer suggested a recent streptococcal infection and the slightly decreased complement would support the diagnosis of glomerulonephritis. On several occasions red blood cell casts were seen in the urine sediment. As shown in Table I there was persistent hypocalcemia and hyperphosphatemia. Her serum alkaline phosphatase was mildly increased. The response of the serum calcium to phosphate binding



FIGURE 2

by oral Amphojel and subsequently Basojel is typical of this disorder in that the serum calcium rises.

Second Patient

ROBERT E. DICKS, B.S., Third Year Medical Student: The second patient MH: ETMH #128-073, a 38-year-old white married house wife was admitted for evaluation and treatment of renal osteodystrophy. There was a history dating back to early childhood of repeated urinary tract infections. This finally progressed to chronic pyelonephritis and renal excretory failure. Most likely she had bilateral ureteral reflux over a period of years and recurrent pyelonephritis as a result of that abnormality. Her symptoms at the time of admission consisted of extreme lethargy, weakness, postural hypotension with dizziness and giddiness, anorexia, nausea, pruritis, arthralgias of the left knee and right shoulder with effusion of these joints in the past, subcutaneous nodules with tenderness and bone pain with bone tenderness. She also complained of polydipsia and polyuria. Three years prior to this admission when she first developed marked symptoms of renal excretory failure x-ray of the bones showed no evidence of osteitis fibrosa, osteomalacia or osteosclerosis.

Physical examination: She was an ill-looking white woman complaining of pain in the right shoulder and some generalized bone tenderness. The

TABLE 1
REPRESENTATIVE LABORATORY DATA CORRELATED
WITH MAJOR THERAPEUTIC MANIPULATIONS

Hospital Day	BUN	Creatinine	Serum Ca ⁺⁺	PO ₄ ⁻	HCO ₃ ⁻	Treatment
2	161	16.2	4.4	11.4	10	
8	228	—	—	—	12	Giovannetti Diet
12	222	18.6	4.4	14.1	9	RBC Transfusion
18	210	—	—	—	13	Peritoneal Dialysis for 3 days
26	119	18	4.8	15.9	16	
30	150	17	5.1	16.8	15	
40	156	16.2	6.0	9.4	13	Amphogel 30 cc.p.o.q.i.d.
46	153	17	4.7	8.7	13	
54	146	18.6	6.6	6.6	14	
60	138	16.5	7.5	6.2	15	Basaljel 30 cc.p.o.q.i.d.
65	134	16.5	6.9	5.0	19	Discharged on Vitamin D 1000 u/daily

blood pressure was 180/110 supine, pulse of 88; 140/90 and pulse 110 in the standing position. She complained of dizziness on standing. The skin was a bronze-olive color with marked hyperpigmentation over the chin. There was mild hirsutism. There were subcutaneous nodules on the inner aspect of the calf of the left leg and right leg and a nodule over the right acromioclavicular joint. All these subcutaneous areas were tender. The mucous membranes were very pale. The optic fundi were normal. There was no evidence of conjunctival calcification. The teeth were very carious. There were several broken teeth and the possibility of some abscesses. The thyroid was perhaps slightly enlarged but there were 2 × 2 cm. nodules on both lower poles of the thyroid which moved with swallowing and perhaps represent parathyroid tissue. There were no pulmonary rales. The heart was slightly enlarged with some left ventricular overactivity. The first and second heart sounds were normal and there were no third or fourth heart sounds. There was a pericardial friction rub heard in the pulmonic outflow tract area and there was a harsh ejection type systolic murmur heard over the same area. There were no bruits heard over the carotid arteries. The liver and spleen were not enlarged and the bowel sounds were normal and no bruit heard over the abdomen. Bone tenderness over both tibiae was present with no tenderness in the skull area. There was deformity of the

acromioclavicular joint on the right side. On neurological examination she was somewhat lethargic with hyperactive deep tendon reflexes and some twitching.

Laboratory Data

The hematocrit was 17 per cent with a normal white count and a slight increase in the eosinophiles. Serum sodium and potassium were normal, and the serum calcium on two separate occasions was 9.5 and 10.3 mg per cent. The serum phosphorus was 11.2 mg per cent. The serum alkaline phosphatase was markedly elevated at 130 IU/ml. Serum creatinine was markedly elevated at 10.6 mg per cent. There was left ventricular hypertrophy by ECG and enlargement on chest x-ray. Typical x-ray findings of renal osteodystrophy were present. There was the typical "salt and pepper" appearance of osteitis fibrosa of the skull (Figure 4). Subperiosteal resorption and some cyst formation was present on x-rays of the hands (Figure 3). There was no evidence of resorption of the distal phalanx of the hands with resultant clubbing. The distal end of the right clavicle was absent consistent with osteitis fibrosa and this is depicted in Figure 5. There was calcification in the joint space. The left femur showed some evidence of subperiosteal reaction consistent with osteitis fibrosa and there was calcification of the posterior tibial arteries. The rugger jersey appearance of the



FIGURE 3

lumbar vertebrae on lateral x-ray views is typical of osteosclerosis. This is shown in Figure 6 and it should be noted that the osteosclerotic bone seems to light up on illumination of the x-ray film. There was no x-ray evidence of osteomalacia.

T. E. TEMPLE, JR., M.D.: Although there are early biochemical and histological abnormalities in renal osteodystrophy, it is the rather late and severe pathology as determined by x-rays of bone and soft tissues which most often confirms the diagnosis for the clinician. These x-ray findings are those of (1) osteomalacia, (2) osteitis fibrosa, (3) osteosclerosis and (4) ectopic calcification or calcification in tissue other than bone.



FIGURE 4

Osteomalacia is usually the earliest skeletal lesion in renal failure and is due to a defect and decrease in mineralization of formed osteoid.¹ This has been demonstrated by radioactive calcium studies and by observation on bone biopsy of increased numbers of abnormally smooth osteoid seams.¹⁻³ The seams of normal mineralizing osteoid are serrated rather than smooth. In osteomalacia not caused by renal failure there is evidence for increased bone mass³ which has a greater proportion of unmineralized or uncalcified bone than is found in normal healthy bone tissue. Hereafter, this uncalcified or unmineralized bone will be referred to as osteoid. However, in renal excretory failure the evidence points to decreased bone mass and decreased net bone formation with an abnormally high amount of osteoid being present.^{4, 5} The overall result is bones, which are less dense on x-ray, are structurally weakened, and fracture easily with minimal trauma. Callus formation will take place in fractures but because of the defect in osteomalacia, mineralization is very slow. Therefore on x-rays these fractures may be seen for long periods of time as non-union of bone. It is of interest that many times the fractures in osteomalacia are symmetrical. Fractures were not demonstrated in either of the patients reported here. In children or patients whose epiphyses have not yet closed, the x-ray changes of osteomalacia are somewhat different from adults and are characterized by frayed or indistinct epiphyseal borders and widened diaphysio-epiphyseal areas. The changes in rickets occur predominately in the wrist, knees and ankle. Costochondral involvement of the ribs results in what is known as rachitic rosary. Osteomalacia in the child often results in bowing of the weight bearing bones, especially of the legs. The frayed and widened diaphysio-epiphyseal area of the proximal humerus as seen in patient ED (Figure 1) and an overall decrease in bone density are typical of rickets or osteomalacia. This child did not have any abnormal bowing or fractures. As determined by x-ray there was no evidence of osteomalacia in the adult, MH, except for decreased bone density.

Bone findings of osteitis fibrosa in patients with chronic renal excretory failure are quite typical. It has been known for decades that parathyroidmegaly occurs in chronic uremia. In fact, parathyroidectomy has been demonstrated to reverse some of the clinical and radiographic manifestations of uremic osteodystrophy.⁶ Thus, little doubt exists that the hyperparathyroidism is a significant disorder in many cases of uremic bone disease. With increased parathyroid hormone secretion there is increased bone turnover. Resorption tends to be more rapid than bone formation which further aggravates the mineral



FIGURE 5

deficiency of bone.⁵ This may be partly responsible for the decreased bone density seen on x-ray. Stanbury reports that osteitis probably always accompanies osteomalacia of uremic osteodystrophy.⁷ The marked increase in bone resorption associated with accumulation of osteoclastic cells and cyst formation can be seen on bone biopsy. Increased bone turnover, that is, increased formation and resorption⁸ is partially responsible for typical x-ray findings in osteitis of bone resorption with adjacent areas of increased bone densities.^{8, 9} This gives the characteristic "moth eaten" or "salt and pepper" effect. This is evident in patient MH (Figure 4). At times small discrete radiolucent areas in the skull can be seen. Often these have thin rims of increased density which represent increased bone formation. Subperiosteal resorption is often demonstrated in the bones of the hands and was present in both of the patients reported here (Figure 3). The resorption can be so severe that complete destruction of various portions of bone can occur as shown in MH and ED by the disappearance of the distal end of their clavicles (Figures 1 and 5). This can also occur at proximal ends of bone. The long bones and terminal ends of the distal phalanges are most often involved. Less severe resorption is characterized by subperiosteal reaction or fuzziness. Loss of the lamina dura of the teeth as seen by x-ray is often found, but x-rays of the hands are much better in determining subperiosteal

teal resorption due to hyperparathyroidism. The bones are weakened by the above and there is tendency for fracture deformity and vertebral collapse.

X-Ray Findings

The x-ray findings of osteosclerosis are rather characteristic in the lumbar and dorsal spine and base of the skull. This is best seen on lateral views of the vertebrae. There are times, however, when osteosclerosis, or increased bone density as determined by x-rays, can occur around the sacroiliac joint and the acetabular area of the pelvis. It looks for all purposes like Paget's disease of the skeleton. The bones involved seem to light up when the x-ray film is illuminated. Osteosclerosis was present in both patients in this report (Figures 2 and 6). In Figure 6 the "rugger jersey" appearance of the lumbar vertebrae is demonstrated. The mechanisms involved in osteosclerosis are unclear. However, it is always associated with very high serum parathyroid hormone levels.^{2, 8, 34}

Parfitt¹⁰ has recently reviewed the subject of ectopic calcification in renal osteodystrophy. By definition this is calcification in areas other than bone such as abdominal viscera, arteries, joints and skin. The most commonly observed pathology is arterial calcification which can be seen quite easily on x-rays of the extremities. Calcification of the posterior tibial arteries was present in patient MH. Small discrete and quite radiopaque shadows of calcification of the atherosclerotic plaques in the tunica intima is less common than the less dense diffuse areas typical of Mönckeberg's arteriosclerosis but can be seen. Periarticular and intra-articular calcification may involve any joint. Patient MH had this in the acromioclavicular joint (Figure 5). Cutaneous calcifications may be a problem in some as it was for patient MH. Apparently there is subcutaneous fat necrosis with calcium deposition which can at times be demonstrated by x-ray. A recent study¹¹ demonstrated only one of 10 patients with uremic hyperparathyroidism to have normal calcium content in the skin.

Until the advent of chronic dialysis and renal transplantation uremic osteodystrophy was uncommon, though not unrecognized. Apparently, conservative measures for managing patients with chronic renal failure did not frequently allow survival to the time when bone changes could be detected by x-rays. It can be considered a disease of medical progress since it is now rare not to find examples of it in hospitals with dialysis and transplant programs. The patients in this report are somewhat unusual. In the child, ED, uremic osteodystrophy was already present when the renal disease was first discovered and x-ray evidence of bone disease was not present in MH three years ago. The clinical manifestations of the renal osteodystrophy are protean in nature since

OSTEODYSTROPHY / Carr, et al.

all organs systems may be involved and are in general caused by: (1) functional changes related to elevated serum calcium, (2) ectopic calcification of various organs systems and (3) bone pathology.

Elevated serum calcium can cause vasomotor instability, hypertension, emotional lability, anorexia, nausea, vomiting, polyuria, polydipsia and pruritis. Most of these are the same problems associated with renal excretory failure. However, the abnormalities in calcium metabolism can make the overall picture worse and the most important fact is that some of the calcium abnormalities are correctable. MH had emotional lability, hypertension, anorexia, nausea, polydipsia, polyuria, pruritis. It is hopeful that with the correction of the hypercalcemia that many of these symptoms will be less severe if not totally relieved.

Problems of Ectopic Calcification

The problems of ectopic calcification are (1) soft tissue calcification associated with subcutaneous fat necrosis and symptoms therefrom; (2) calcification in the conjunctivae with resulting band keratopathy uveitis, and the red eye syndrome; (3) deposition of calcium within the joint spaces to cause arthritis, arthrosis, and joint deformities (this arthritis is often mistaken for gout) and (4) calcification of arteries which can result in ischemic syndromes of various organs, most often ischemic ulcers of the extremities.^{10, 12}

Patient MH of this report demonstrates arterial and joint calcification. She also experienced subcutaneous fat necrosis which resulted in palpable tender nodules in the subcutaneous tissue of the leg. ED of this report did not have ectopic calcification.

Enlargement of the parathyroid glands involved in the pathology of the entire renal osteodystrophy syndrome may be a problem because it occurs in the thyroid area and the differential diagnosis is a goiter versus enlargement of the parathyroid gland. Patient MH was a good example of this as there was marked enlargement in both lower poles of the thyroid which most likely represents enlarged parathyroid glands.

Severe Clinical Manifestations

Clinical manifestations of bone involvement in this disease are severe. These are bone pain, bone tenderness, fractures with minimal trauma, bowing and deformities of weight bearing bone and resorption of various portions of bones; all resulting in the loss of function and structural weakness. For instance, the resorption of the distal end of the phalanges of the hands can cause telescoping of the fingers, marked deformity which results in a grotesque appearance and also impairs the functional

ability of the hands. Bone pain and involvement in the pelvic area often causes a typical waddling gait and difficulties in walking. This is especially true of children. Also bowing of the tibiae in children can cause marked deformities in gait. Although in patient ED there is no definite deformity of the bones on x-ray, there is evidence for rickets in the proximal humerus and the loss of the distal end of the clavicle which results in weakness of those bones. She did have impairment of growth. This could be the result of the renal excretory failure as well as bone involvement. The important factor is that many of these complications can be prevented or at least decreased in severity by controlling abnormalities of calcium metabolism.

ALBERT A. CARR, M.D.: A simple explanation of what altered physiological or pathological processes cause bone disease in renal excretory failure is impossible at our present state of knowledge. Generalized alterations in physiological or pathological processes cannot totally explain this disease since ectopic calcification and different bone defects such as osteomalacia, osteitis fibrosa, and osteosclerosis may occur concomitantly.¹³ Individual local bone factors such as: (1) metabolic activity, (2) blood supply, (3) type of bone (cortex or spongy—cancellous) and (4) physical stress forces, are important. Bone is formed in the growing child by two processes: (1) endochondral formation which accounts for growth in length and (2) intramembraneous formation. Since there is net accumulation of bone in the growing child it is obvious that the balance of the ever-active process of bone formation and resorption is shifted such that formation exceeds resorption. In contrast, this dynamic activity of formation versus resorption, or turnover, is in a state of balance in the young adult where bone growth in length has ceased and no new net accumulation or loss occurs. There is evidence to support the view that after the third or fourth decade of life there is gradual loss of bone mass indicating resorption is then greater than formation. The bone disease in renal excretory failure may be considered a result of alterations in the usual dynamic equilibrium between bone formation and resorption for the age of the patient. The net result is loss of bone mass and changes in portions of remaining bone.

However, the one factor which predominates early is negative calcium balance which is due to an impaired gut calcium absorption while significant urinary excretion continues.^{14, 15} Therefore, it follows that plasma and urine calcium have to be maintained at the expense of bone resorption. This negative calcium balance plus resistance to the actions of parathyroid hormone¹⁶ and Vitamin D¹⁷ on bone may be the predominant cause of the renal osteodystrophy syndrome.

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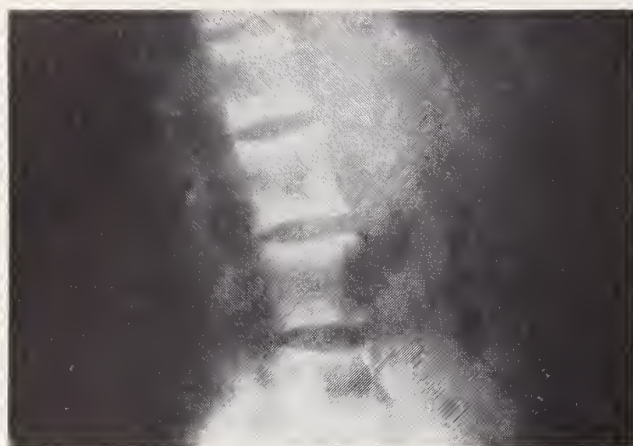


FIGURE 6

Gut Calcium Absorption

Gut calcium absorption as determined by radioactive calcium studies is decreased as renal failure progresses. When the serum creatinine approaches 2.5 mg per cent or glomerular filtration rate decreases to 30 ml/minute, gut calcium absorption is approximately half of normal.¹⁴ Plasma parathyroid hormone levels as measured by immuno-assay are elevated at a time when plasma calcium is normal or low.¹⁶ This indicates that bone resorption is depressed even in the presence of elevated plasma parathyroid hormone and this can be documented when the serum creatinine increases to 1.5 mg per cent or above.¹⁸ This can be considered bone resistance to parathyroid hormone. In addition, there is impaired response of bone to Vitamin D early in renal excretory failure.¹⁷ It is known that the action of parathyroid hormone on bone is markedly impaired in the absence of Vitamin D.^{19, 20} Therefore, abnormalities in Vitamin D metabolism could result in Vitamin D and parathyroid hormone resistance. Recent evidence has established that it is the metabolic products of Vitamin D which are responsible for its action on bone and gut.^{21, 22} Vitamin D is hydroxylated in the liver to 25 hydroxycholecalciferol.²³ This is further hydroxylated to 21,25 dihydroxycholecalciferol which is active mostly on bone to cause resorption.²¹ Another product, 25,26 dihydroxycholecalciferol stimulated mainly gut calcium transport.²² Recently it has been shown that the hydroxylation of 25 hydroxycholecalciferol to 1,25 dihydroxycholecalciferol takes place in the kidney and this product seems to have marked bone activity.²⁴ It follows that renal disease can reduce the conversion of Vitamin D; thus resistance. It may be the product which is active in stimulating gut calcium transport is also produced in the kidney and is partially responsible for the impaired gut calcium transport.

The effects of Vitamin D on bone are very important in the maintenance of plasma calcium and bone formation.²⁵⁻²⁹ In man, in the presence of osteomalacia caused by Vitamin D deficiency, intravenous calcium in the absence of Vitamin D will not correct hypocalcemia even though positive calcium balance occurs. In contrast Vitamin D administration results in a rise in serum calcium even though positive calcium balance is not as marked as with the intravenous calcium.²⁹ This means the effect of Vitamin D on mobilization of calcium from bone is important. Results of animal experiments support the conclusion that a direct effect of Vitamin D on bone is necessary for healing of rickets.²⁵⁻²⁸ Calcium is mobilized from bone, resulting in a rise in serum calcium which is then available for new bone formation or healing of the rickets.

Thus, early in renal excretory failure impaired gut calcium transport and impaired mobilization of calcium from bone can be explained on the basis of altered Vitamin D metabolism resulting in deficiency of the active Vitamin D product (Vitamin D resistance) and parathyroid hormone resistance. This is the perfect set of circumstances for the development of osteomalacia. Plasma calcium tends to be normal or low and the $\text{Ca} \times \text{P}$ product is invariably lower than 70.³⁰ Abnormalities in the physico-chemical relationship between calcium, phosphate and mineralization of osteoid may not be the total explanation since there is evidence for retention of a peptide and pyrophosphates in renal failure, both of which inhibit normal mineralization.^{31, 32} However, all of these certainly set the stage for defective mineralization of osteoid to produce osteomalacia.

Healing of Osteomalacia

As renal excretory failure progresses and glomerular filtration decreases below 20-30 ml/minute the serum phosphate begins to rise.³³ Plasma parathyroid hormone concentration rises to greater proportion associated with marked increase in size of the parathyroid glands.¹⁸ Bone resorption or osteitis then becomes the predominant clinical picture. Possibly the resistance to parathyroid hormone is overcome by the strikingly high parathyroid hormone levels. Healing of the osteomalacia can then take place.¹⁷ Plasma calcium rises and the $\text{Ca} \times \text{P}$ product is then generally above 70.³⁰ All the clinical problems of hyperparathyroidism then follow. At this time the changes of osteosclerosis are often present. The reason for osteosclerosis is unclear but high levels of parathyroid hormone are necessary.³⁴ Perhaps it is due to the marked increase in bone turnover. As bone calcium is mobilized more is available for healing of the osteomalacia, which produces more radiodense areas.

As the $\text{Ca} \times \text{P}$ product rises further the circumstances for ectopic calcification occur. It is unclear why there is a predilection for certain tissues. Perhaps tissue pH, collagen content and presence or absence of inhibitors of the calcification process are important. The ectopic calcification is usually associated with $\text{Ca} \times \text{P}$ products much greater than 70.^{10, 30}

There are other factors involved in renal failure such as poor nutrition and acidemia may result in subnormal production of osteoid necessary for bone formation. These occur late in the course of the renal failure and cannot be implicated in the genesis of the bone disease.

It does appear that negative calcium balance and defective Vitamin D metabolism, which actually causes Vitamin D deficiency and parathyroid hormone resistance, are the main factors most likely responsible for the syndrome. As glomerular filtration rate approaches 30 ml/minute methods should be used to prevent the negative calcium balance. The administration of Vitamin D early may prevent or prolong the appearance of bone disease. In the future, if the active components of Vitamin D metabolism in the kidney such as 1,25 dihydroxycholecalciferol are available these will be ideal replacement hormones. This possibly could prevent the entire complex. When patients are on a chronic dialysis program the bath calcium concentration of the dialysis unit should be such that slight positive calcium balance takes place. Once florid hyperparathyroidism takes place with normal to high serum calcium the treatment of choice is the removal of three and one-half of the parathyroid glands.

The use of phosphate binders such as Maalox at times can be useful in lowering the $\text{Ca} \times \text{P}$ product and hopefully prevent further ectopic calcification. Recently it has been demonstrated that when bath dialysis magnesium was raised to 2.5 mEq/L during chronic hemodialysis the serum parathyroid hormone levels decreased. Thus, control of magnesium intake may be important.³⁵ Maalox does contain magnesium. Finally, thiazide diuretics should be used with caution since such treatment may precipitate a marked rise in serum calcium.³⁶

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OSTEODYSTROPHY / Carr, et al.

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COBB COUNTY MEDICAL SOCIETY SPONSORS SYMPOSIUM '72

April 13-14, 1972

The Cobb County Medical Society, through its Committee on Medicine and Religion, will sponsor Symposium '72 on April 13-14, 1972. The sixth annual symposium, "The Search for Relevance in the Seventies," will be held at Kennesaw Junior College, Marietta.

Bill Curry of the Baltimore Colts will be featured at the April 13, Thursday evening session, speaking on "The Relevance of Sports in America." He will be followed by Dr. H. Douglas Sessoms, University of North Carolina at Chapel Hill, who will talk on "The Meaning and Relevance of Leisure."

The Friday morning session will be kicked off by Dr. Eugene Odom, director of the Institute of Ecology at the University of Georgia, speaking on "The Relevance of Ecology." Dr. Elizabeth Kubler-Ross, international consultant on the care of the dying patient and involved families, as well as renowned authoress, will present "The Relevance of Death and Dying." "The Relevance of Religion" will be presented by Dr. Edmund A. Steimle, of the Union Theological Seminary in New York. Luncheon will be served.

Panel discussions involving all the speakers with questions from the audience will fill the afternoon session. The Honorable Robert H. Hall, justice of the Court of Appeals of Georgia and president of the American Judicature Society, will moderate.

The Honorable Hugh Scott, minority leader of the U. S. Senate, will deliver the closing address Friday evening, April 14, in the Phoenix Ball Room of the Regency Hyatt House in Atlanta. He will be introduced by The Honorable David Gambrell, of Georgia.

This program has been approved for 8 elective hours by the American Academy of Family Practice. Information regarding application for registration, etc., may be obtained by writing Symposium '72, Kennesaw Junior College, Marietta, Georgia 30060.

Porphyria

STEWART E. WIEGAND, M.S., M.D., *Sandy Springs*

THE PORPHYRIAS comprise a group of diseases which are among the most unusual ailments in medicine. Although the group has in common the abnormal metabolism of the precursors of Heme, it includes diseases with very diverse clinical presentations. Some diseases within the group are inherited (autosomal dominant, five types; autosomal recessive, one type), while some diseases within the group are acquired.

Classification of Porphyrias

Porphyrias can be subdivided tentatively into two subgroups of diseases. One subgroup contains diseases which probably are caused by abnormal porphyrin synthesis in the liver, while the other subgroup contains diseases which are caused by abnormal porphyrin synthesis in the bone marrow (Chart I).

Clinical Presentations of the Porphyrias

Acute Intermittent Porphyria (Swedish Genetic Porphyria—Pyrrolporphyria) is characterized by four cardinal signs, or symptoms. A patient usually will present with a combination of two, three or all of the symptoms described below; however, a patient may present with only one of the symptoms.²⁹

1. The patient may present with diffuse, nondescript but sometimes severe *abdominal pain*, which may be associated with vomiting, constipation, and a tachycardia. The entire episode of this symptom may be a duration of a few days, or it may be as long as several weeks. There may be surgical scars on the patient's abdomen from prior attempts to diagnose and treat the pain.

2. The patient may present with *psychic disturbances* which range from personality changes to acute mania. A hysterical reaction to severe abdominal pain may explain the patient's behavior in some episodes.

3. The patient may present with a peripheral neuropathy. Initially, this symptom should be distinguished from muscle spasms which are also de-

scribed with acute episodes of this disease. The patient may develop flaccid quadraplegia and respiratory paralysis due to acute demyelination which can affect both the somatic and the autonomic nervous systems. There may be residual neurologic damage if the patient survives the acute episode.

4. Shortly before, during the course of, and shortly after the acute episode, the patient may pass excessive amounts of *delta amino levulinic acid and uroporphobilinogen (colorless compounds) into his urine*. These pyrrols may spontaneously cyclize into the dark colored porphyrins (uroporphyrin and some coproporphyrin). This process is enhanced by time, acidity of the urine, and, possibly, by exposure to sunlight. The Schwartz-Watson test performed on this urine (whether the urine is dark-colored or not), will be positive. During remission the Δ ALA and PBG may disappear from the urine.²⁹

This disease is inherited as an autosomal dominant. About 65 per cent of the reported cases are from Sweden. Of the reported cases, 60 per cent are female. Waldenstrom reports having records of over 600 Swedish cases.⁶¹

The patients are not sun sensitive but occasionally develop a generalized darkening of their skin. Chart II designates the major drugs that will precipitate or intensify an acute episode. Fatality may result from using a barbiturate as a pre-anesthetic for surgical exploration. However, Demerol and Thorazine can be used to treat the abdominal pain, peripheral neuropathies, and psychic disturbances. The disease usually first appears in about the third decade of life, and may be associated with hyperbeta lipoproteinemia.³⁰

Porphyria Variegata

Porphyria Variegata (Porphyria Cutanea Tarda—Hereditaria South African Genetic Porphyria—Mixed Porphyria, Proto-coproporphyrin) clinically resembles acquired type P.C.T., but in addition, the patient may have occasional episodes resembling A.I.P. The disease is inherited as an autosomal dominant and was traced by Dean (in 1959) to a single marriage of two Dutch settlers in South Africa in the year 1688.⁵ There are about 9,000 cases alive to-

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CHART I	
CLASSIFICATIONS OF THE PORPHYRIAS	
A. Liver	
1. A.I.P.	Acute Intermittent Porphyria
2. P.V.	Porphyria Variegata
3. P.C.T.-A.	Porphyria Cutanea Tarda-Acquisita
4. C.-H.	Coproporphyria-Hereditaria
B. Bone Marrow	
1. C.E.P.	Congenital Erythropoietic Porphyria
2. C.E. proto P.	(Congenital) Erythropoietic Proto Porphyria
3. C.E. copro P.	(Congenital) Erythropoietic Copro Porphyria

day.⁷ The symptoms usually first occur in the second or third decade of life. The men tend to have a greater share of the skin manifestations than do women, while the women tend to have A.I.P.-like episodes.⁵ The A.I.P.-like episodes may consist of abdominal pain, neuritis or psychic problems, and dark colored urine. The neuritis of P.V. is distinguished from the neuritis in A.I.P. in that, if the patient survives the episode (the greater majority do), there is no residual nerve deficit. Between episodes the patient may have excessive stool and urine coproporphyrins, and stool protoporphyrins, but with the episodes there is an outpouring of porphobilinogen as in A.I.P. Rimington and his associates have reported in this condition a hydrophylic porphyrin (designated X porphyrin) similar to uroporphyrin except that it is bound to protein.^{46, 47} The same drugs that precipitate acute episodes in A.I.P. precipitate similar episodes in P.V. (Chart II).

Porphyria Cutanea Tarda-Acquisita (Symptomatic) (North American Cutaneous Porphyria, Uroporphorphyria, Constitutional Porphyria, Turkish Porphyria, African Bantu Porphyria) is clinically characterized by the features listed in Chart III. Although the great majority of cases present with an acquired disease not found in other members of the same family, some investigators suggest that a genetic propensity for the disease may be necessary in order to acquire it. The onset usually is from the fifth through the seventh decades, although onset in childhood has been reported.⁶⁴ It is more common in males than in females in the United States. The precipitating factors are listed in Chart II. The patients characteristically have excessive urinary and stool uroporphyrins, and urinary and stool coproporphyrins. The patients do not have episodes of abdominal pain or peripheral neuropathies.

In 1957 the United States supplied Turkey with

wheat treated with the fungicide Hexachlorobenzene. The wheat was intended for planting but was made into bread, etc., and sold in the markets. About 5,000 cases of porphyria resulted, mostly in children.⁵ Clinically, they resemble the American style of P.C.T., with an additional feature of very marked facial and body hair growth, resulting in the patients being given the appellation "Monkey Children." Biochemically they resemble other acquired P.C.T.s. Acquired P.C.T. also is seen notably in the wine farming families of Cape Town, South Africa, and in the urbanized, beer-drinking South African Bantu, who may have nutritional cirrhosis as well.⁵

Malignant⁵⁷ and benign tumors⁵ of the liver may be associated, rarely, with acquired P.C.T.

CHART II			
EFFECT OF DRUGS ON PORPHYRIA			
	AIP	PCT-H	PCT-A*
Barbiturates†	++	++	0
Sulfonamides	++	++	0‡
Griseofulvin	++	++	0§
Estrogens ⁵⁰	++	+	+
Alcohol	+	+	+
Chloroquine	?	?	++

+ Adverse effect.
++ Marked adverse effect.
0 No effect.
? Unknown.
‡ Possibly Sulfonal (Sulfonomethane).
§ May aggravate an extant case, but probably will not induce the disease.⁴⁹
* Hepatomas⁵⁷ Hexachlorobenzene, 2-4 Dichlorophenol, 2-4-6 Trichlorophenol, and possibly Arsenic, Chlordiazepoxide (Librium),⁵⁹ Meprobamate (Miltown),⁵⁹ Isopropylmeprobamate (Soma),⁵⁹ Diphenylhydantoin (Dilantin),⁵⁹ Methsuximide (Celontin),⁵⁹ Tolsutamide (Orinase),⁵⁹ and Ergot derivatives⁵⁹ may precipitate this disorder.
† Recent reports indicate that Phenobarbital may prevent excessive ALA synthetase formation, thereby protecting the patient with hepatic porphyrin.²⁷

Coproporphyria Hereditaria

Coproporphyria hereditaria is inherited as an autosomal dominant. This disease is biochemically and clinically similar to P.V. except that excessive protoporphyrins are not found in the stool, and (exclusive of one reported case of a patient with sun sensitivity), there are no cutaneous manifestations.¹⁷ There are about 30 reported cases of Coproporphyria hereditaria.

Congenital Erythropoietic Porphyria (Gunther's Porphyria) is inherited as an autosomal recessive found in equal numbers in both male and female. There were about 65 cases reported from the first description of the disease made in 1874, until 1966. The cases have a very wide geographic and racial distribution. Historians have theorized that patients

afflicted with this disorder may have represented the werewolves of the Middle Ages in Europe.⁵⁴ They clinically may present with increased facial or body hair growth, brown teeth, sclerodactylia, severe scarring, and generalized melanosis. Marked sun sensitivity and photophobia may have prompted sufferers to venture out of shelter only at night.

Biochemically, patients with this disease have excessive urine and stool uro- and coproporphyrins, resulting in dark colored urine. The disease is thought to be caused by a defect in the bone marrow. About 5 per cent of the nuclei of proerythrocytes will give a relatively persistent fluorescence using appropriate ultra violet light (UVL). The cytoplasm of the cell also may fluoresce.⁶ Roentgenographs are said to show characteristic atrophy of the terminal phalanges, decreased density of the cancellous parts of long bones, and occasional soft tissue calcifications.⁵⁵

Congenital Erythropoietic Protoporphyrria is inherited as an autosomal dominant with incomplete penetrance and is twice as common in males as in females. It was first described by Magnus in 1961.³⁴ Since then, so many cases have been reported that its true incidence would be difficult to estimate.⁴⁰ Many of the cases of Hydroa Estivale reported prior to 1961 probably represent this entity.⁴³ Symptoms characteristic of this disease include the presence of pruritis, erythema, edema, or hives following sun exposure. A history of burning pain 20 minutes after exposure to sun that has passed through window glass (i.e., long UVL) is very suggestive of protoporphyrria. The onset of the disease usually occurs in childhood. The chronic cutaneous manifestations are "chicken wire" scars on the cheeks and nose, thickened, rugose skin over the dorsum of the hands, and slight hyperpigmentation of exposed skin.²⁸ There is an increased incidence of gallstones in protoporphyrrias.⁶ Only one fatal case has been reported; in that case, the patient's disease was associated with hepatic cirrhosis.⁹ In some patients the disease may disappear at puberty.

Biochemically, patients with this disease have an increase in stool, serum, or Rbc protoporphyrins, and an increase in Rbc and serum coproporphyrins. This disorder is thought to be caused by a bone marrow defect with 15 per cent of the normoblasts revealing a transient fluorescence of their cytoplasm. About 15 per cent of the peripheral blood erythrocytes also fluoresce. It is reported that the liver also contributes to the synthesis of protoporphyrin in this condition.⁶

Erythropoietic Coproporphyrria is clinically identical to erythropoietic protoporphyrria, except that erythrocyte coproporphyrins are found in greater excess than are erythrocyte uroporphyrins or proto-

CHART III
PORPHYRIA CUTANEA TARDA-ACQUISITA
CLINICAL MANIFESTATIONS
Red, purple, or dark urine
Sun sensitivity of exposed areas
Blisters on exposed areas; secondary scarring
Suffusion of face and upper trunk
Conjunctival injection—"blood shot eyes"
Darkening of scalp and eyebrow hair
Hypertrichosis of face
Hyperpigmentation of exposed areas; occasionally generalized
Sclerodermoid appearance of hands, face, and neck
"Morphea" of chest and trunk
Comedones of hairline
Discrete pigmented macules of hands and face

porphyrins. There is only one reported case, which occurred in the daughter of a woman with elevated erythrocyte coproporphyrins.⁵

Biochemistry of Porphyrrias

The porphyrins are metabolic intermediates in the synthesis of Heme. A simplification of the general pathway is illustrated in Chart IV. The inserted numbers represent enzymes.

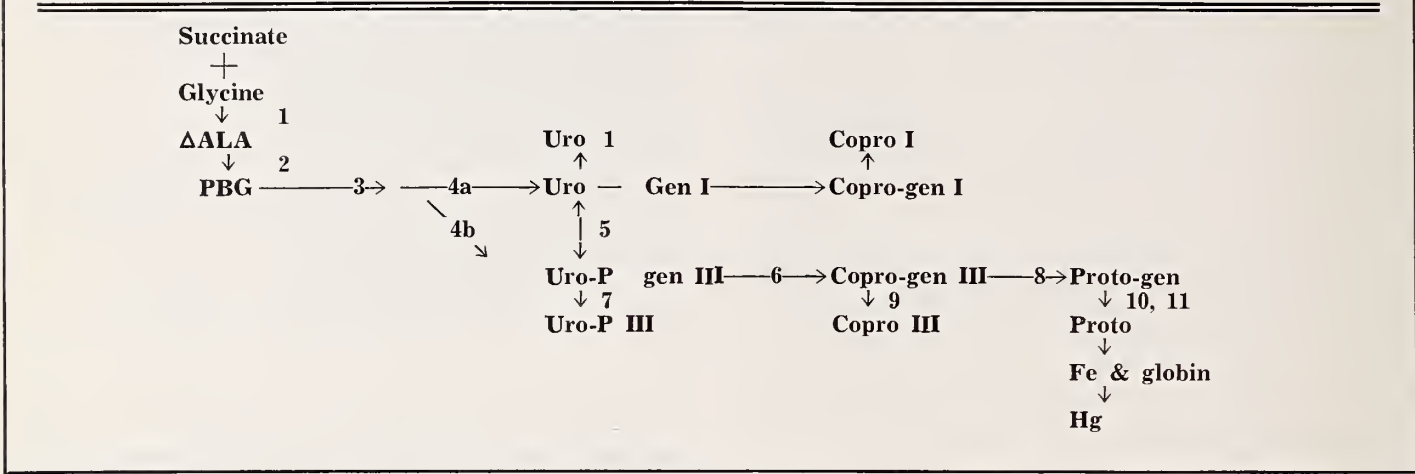
Enzyme 1 (Delta Amino Levulenic Acid synthetase) generally has been considered to be the rate-limiting enzyme for the porphyrin metabolic pathway. It is synthesized de novo in excess in the hepatic porphyrias, according to Granick.¹⁹ The defect was thought to be an abnormality in the negative feedback system in which Heme and aporepressor no longer adequately repressed the operator gene responsible for the synthesis of Δ ALA synthetase.¹⁹ Recently, a substance has been found in human plasma capable of inducing this enzyme.²⁵ Other authors have confirmed the presence of an excess of this enzyme in A.I.P.,²⁶ P.V.¹¹ and P.C.T.-A.³¹ Recently, Marver found that it was not increased in P.C.T.-A.²⁶

Enzyme 4a was suggested as responsible for overproduction of the porphyrin I series in C.E.P.,⁵⁸ in association with a defect in enzyme 5,^{5, 51} not allowing the isomerization of the I isomer to the III isomer of uroporphyrinogen. Romeo recently found in his laboratory that enzyme 5 was decreased, but that enzyme 4a was normal in C.E.P.⁵¹

Enzyme 4b has been found to be decreased in A.I.P.,³⁶ and normal in P.C.T.-A.³⁶ This may account for the 20 per cent reduction of mean blood volume in A.I.P.

A deficiency in enzymes 6 and 8 was suggested by Waldenstrom and Haeger as the defect in P.C.T.-A.⁶² Hellman²¹ and Rimington⁴⁵ suggested that an overactivity of enzymes 7 and 9, due to a shift of the re-dox potential in the liver, accounted for the bio-

CHART IV
METABOLISM OF PORPHYRINS



Uro-gen = uroporphyrinogen
Copro-gen = coproporphyrinogen
 Δ ALA = delta amino levulenic acid
PBG = porphobilinogen

Enzyme

- 1 delta amino levulenic acid synthetase
- 2 delta amino levulenic acid de-hydrase
- 3 porphobilinogen deaminase
- 4a uroporphyrinogen I synthetase
- 4b uroporphyrinogen III synthetase
- 5 uroporphyrinogen isomerase

Uro-P = uroporphyrin
Copro-P = coproporphyrin
Proto P = protoporphyrin
Proto-gen = protoporphyrinogen

Enzyme

- 6 uroporphyrinogen de carboxylase
- 7 uroporphyrinogen oxidase
- 8 coproporphyrinogen decarboxylase
- 9 coproporphyrinogen oxidase
- 10 Heme synthetase
- 11 glutathione

Note: Enzyme 4b and 5 may be identical. Enzyme 3 and 4a may be identical.

chemical findings in P.C.T.-A. Uroporphyrin and Coproporphyrin apparently cannot be returned to their reduced states in vivo.

Tschudy suggested that C.E.P. additionally had a deficiency of Heme synthetase (10) to account for the anemia.

As a result of these defects (or, perhaps, in spite of ignorance concerning the actual defects), diagnosis can be made on the basis of the excess porphyrin produced, as illustrated in Chart V. The example values are listed as 1+, 2+, etc. because of the wide variation of specific values in different patients and in different laboratories.

Excessive porphyrin metabolism may occur secondary to other diseases or to toxins, but is not considered to indicate a diagnosis of porphyria. Lead intoxication can cause excessive urine uroporphyrins; it also can cause stool and urine coproporphyrins. Excessive urine coproporphyrins can be found secondary to polio, liver diseases, acute alcoholism, hemolytic anemia and Hodgkin's disease. Excessive stool protoporphyrins will appear after an episode of gastrointestinal bleeding.

Vitamin tablets may cause the urine to be a deep yellow color, but the urine will not fluoresce the characteristic orange-red color of porphyrins.

Relationship Between Iron and Porphyrin
Cutanea Tarda-Acquisita

Patients with P.C.T.-A. sometimes are found to have elevated serum iron, or greater than 70 per cent transferrin saturation.¹⁴ This is thought to be due to increased absorption rather than decreased utilization of iron.¹⁵ P.C.T.-A. is occasionally associated with polycythemia and with abnormal liver function tests.^{12, 41} Many authors have said that repeated phlebotomies ameliorate the clinical symptoms as well as the porphyrinurea of P.C.T.-A. patients.^{2, 14, 63} This amelioration possibly is caused by stimulation of Heme synthetase.¹⁵ However, there has been no consistent relationship between serum or bone marrow iron stores, the degree of transferrin saturation, and the effects of phlebotomies.²⁴ The relationship between P.C.T.-A. and iron remains essentially unknown.^{32, 41} Recently, aspiration biopsy of the liver and semi-quantitative grading of the fluorescent material have been described as useful tools for diagnosing P.C.T.-A.¹³

Proposed Mechanisms for Phototoxicity
of Porphyrins

Porphyrins in skin are photo reactive compounds.

They absorb energy (particularly ultraviolet light of about 4000 Å wavelengths),⁴⁸ causing the porphyrin molecule to change from the ground state (unenergized) to the singlet; then to the triplet state (energized).³³ After a small fraction of a second, the porphyrins spontaneously return to the ground state, releasing their energy to surrounding molecules which make up the various constituents of skin. The surrounding molecules possibly may be damaged by resultant oxidation.³³

Experimentally, uroporphyrins, coproporphyrins, and protoporphyrins have been injected into the skin of rodents, followed by irradiation with 4000 Å UVL, resulting in damage to the lysosomes of adjacent cells and a subsequent release of the hydrolytic lysosomal enzymes.³³ Histamine is also released at this time.³³

Hematoporphyrin injected into skin, followed by UVL irradiation, has been shown to cause the depolymerization of hyaluronic acid. Hematoporphyrins, however, do not occur in the porphyrias in man.³³

Lead intoxication and iron deficiency anemia may result in elevated Rbc protoporphyrins, but not in sun sensitivity; consequently, sun sensitivity in protoporphyria seems to be caused by elevated serum, rather than by Rbc protoporphyrin.⁴⁴

Therapy of the Porphyrias

Acute Intermittent Porphyria usually is diagnosed and treated by internists and surgeons; seldom by

dermatologists. Prevention of an attack by avoidance of the drugs listed in Chart II is obviously indicated. Therapy for the attack consists of replacing, with intravenous saline, the sudden drop in sodium and chloride that occurs with the attack. Demerol or Thorazine can be used safely for pain or psychic disturbances. A respirator is used if respiratory paralysis supervenes. Chelators such as EDTA and Dimercaprol are used commonly. Adenosine mono phosphoric acid, which supposedly promoted the more efficient synthesis of purines instead of porphyrins, no longer is considered useful.⁶⁵ Actinomycin-D has been proposed recently as an effective treatment.⁶⁷ Patients with this disease are not sun sensitive and, therefore, they require no particular protection from the sun.

The acute episodes of porphyria variegata are treated in an identical manner, with the addition of Propranolol, an adenergic blocking agent, which has been reported to ameliorate acute episodes.¹ The sun sensitive features of P.V. can be treated in the same manner as those of P.C.T.-A., which are discussed below.

The most important point in the therapy of Porphyria Cutanea Tarda-Acquisita is the identification and prohibition of the offending drug. Alcohol is the most common cause, and is difficult to prohibit.⁴⁸ When alcohol or another drug is stopped, and that drug has induced the disease, the patient usually has a gradual recovery within the next following months.

CHART V

	ΔALA Urine	PBG Urine	Uro P				Co pro P				Proto P			X Porphyrin	
			Urine	Stool	Plasma	Rbc	Urine	Stool	Plasma	Rbc	Stool	Plasma	Rbc	Urine	Stool
A.I.P.	3+ [#]	3+ [#]	1+ [#]	1+ [#]			±	1+ [#]			1+ [#]				
P.V.	3+ [#]	3+ [#]	1+ [#]		±		1+	3+	±		3+			1+	1+
P.C.T.-A.			3+	1+	±		1+	1+	±						
C.-H.	3+ [#]	3+ [#]	1+ [#]	1+	1+	1+	3+	3+	2+	2+					
C.E.P.			3+	2+	2+	3+	3+	2+	1+	3+	1+		1+		
C.E. proto P.								+	1+*	1+*	1+*	1+*	3+*		
C.E. copro P.						2+		+		3+			1+		

Note: Protoporphyrin is not found in the urine.

* In protoporphyria the excess protoporphyrin may be found in just one or in a combination of the blocks marked. Excessive plasma protoporphyrins appear more likely to be associated with photosensitivity than does Rbc protoporphyrin.

- # = During A.I.P. or A.I.P.-like episodes
- ± = Sometimes present or sometimes elevated
- 1+ = slight
- 2+ = moderate
- 3+ = marked

- ΔALA = Delta amino levulenic acid
- PBG = porphobilinogen
- Uro P = uroporphyrin
- Copro P = coproporphyrin
- Proto P = protoporphyrin

- A.I.P. = Acute Intermittent Porphyria
- P.V. = Porphyria Variegata
- P.C.T.A. = Porphyria Cutanea Tarda-Acquisita
- C.-H. = Coproporphyrin-Hereditaria
- C.E.P. = Congenital Erythropoietic Porphyria
- C.E. proto P. = (Congenital) Erythropoietic proto Porphyria
- C.E. copro P. = (Congenital) Erythropoietic copro Porphyria

PORPHYRIA / Wiegand

P.C.T.-A. caused by hepatic tumors usually is relieved by removal of the tumor.

The second most important therapeutic point is the protection of the patient from UVL by means of sun avoidance, wide brimmed hats, long sleeved shirts, gloves, and sun screens.

Additional Approaches

Additional therapeutic approaches can be discussed under four headings: Phlebotomy; Chloroquine; Metabolic Alkalinization; and, Chelation.

Phlebotomies are considered by many authors to be helpful,^{14, 32, 42, 63} but others are less enthusiastic.^{8, 23} The mechanism of action is unknown,^{24, 32, 41, 53} but therapy is said to relieve the clinical symptoms, reverse the abnormal liver function tests, and reduce the excretion of porphyrins. The procedure involves the removal of 500 cc of whole blood at three-day to one-month intervals, until a cure is obtained. "Significant" anemia is considered to be contraindication by most authors, although some will give the patient supplemental iron in order to continue the bleedings.¹⁴

Chloroquine has been contraindicated classically for P.C.T. Saltzer, Redeker, and Wilson, in 1968,⁵² used 0.5 gm twice a week for seven months, resulting in significant toxicity (notably fever and malaise), associated with a great increase in urine porphyrins, followed thereafter by improvement in clinical symptoms, liver function tests, and return of serum iron and urine porphyrin levels to normal.

In 1970, Vogler, Galambos and Olansky,⁶⁰ used 0.5 gm q.d. for eight days and obtained similar results. In 1970, Hunter and Donald²² used 75 mg twice a week for the same good results, and with very little or no toxicity.

The mechanism is thought to be the binding of chloroquine to porphyrin, then subsequent rupture and release of the porphyrins from the mitochondria and lysosomes of hepatic cells. Electron microscopy shows extensive mitochondrial damage.

Metabolic alkalinization involves giving the patient 4-5 grams of sodium bicarbonate in divided doses q.i.d. and attempting to keep the urine at an alkaline pH.³⁸ After an initial outpouring of porphyrins there may be a return toward normal of serum iron, liver function tests, and urine porphyrin levels.⁶⁶ The patient may be improved clinically and there is no toxicity. Polycitrate, beginning with 15 mg q.i.d., could be tried if excess sodium is contraindicated in the patient.

Porphyrins are polyvalent weak organic acids. Coproporphyrin has an effective pKa of 7.2, and at an acid pH it is unionized and fat soluble; it will not

cross a lipid biologic membrane. (Above a pH of 7.2, the coproporphyrin is greater than 50 per cent ionized and water soluble, but not fat soluble; and, it will not cross a lipid biologic membrane.)³⁷ If coproporphyrin is passed into urine when the pH is above 7.2, the ionized portion will not back-diffuse passively through the distal renal tubular wall.³⁷ Therefore, by alkalinization of the urine to a pH of 7 to 8, coproporphyrin, once filtered or secreted into the renal tubule, will tend to remain within the tubule and to be excreted.⁴ If coproporphyrin is excreted in amounts greater than its production, the body content will be depleted gradually.

In the porphyrin metabolic pathway, uroporphyrinogen is converted to coproporphyrinogen. It seems reasonable to suppose that the elevated stores of uroporphyrin also will be depleted as newly formed uroporphyrinogen is directed toward coproporphyrinogen, when coproporphyrin has been depleted.⁶⁶

Many chelation agents have been tried in the treatment of P.C.T. Desferrioxamine is thought to be useless.⁵⁶ However, d-penicillamine²² and cholestyramine⁵⁶ have been reported to be useful. Another chelator, sodium calcium EDTA, which possibly chelates both Zn⁺⁺ and porphyrins,⁵⁰ is reported to give excellent clinical results.

Congenital Erythropoietic Porphyria is treated by sun protection and metabolic alkalinization.³⁹ Induced polycythemia may decrease temporarily the synthesis of porphyrins,²⁰ but probably is a demonstration of a negative feedback system rather than a possible form of therapy.

Protoporphyrin is treated mainly by sun protection and sun screens, particularly Dihydroxy acetone and Lawsone cream.¹⁶ The latter has not been found useful by all investigators.¹⁰ Antihistamine therapy is generally disappointing.³³ Vitamin E was found to be of abnormally low serum level in six of seven protoporphyrins and beneficial when administered to all seven of these patients.¹⁸ Perhaps the most interesting development in the therapy of protoporphyrin is oral B. carotene. The three patients treated with oral B. carotene showed marked clinical improvement.³⁵

Carotinoids are photo reactive compounds and are known in photobiology to quench free radicals and singlet-excited oxygen. It has been considered possible that the carotinoids protect the porphyrins from photoreactivity by absorbing the UVL that reaches the skin. (It also has been noted that a decrease in plasma protoporphyrins, but not Rbc or stool protoporphyrins, occurs.) This new form of therapy seems worthy of further investigation.³⁵

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PORPHYRIA / Wiegand

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REPORT OF COMMITTEE ON CONSTITUTION AND BYLAWS

At the 1971 meeting of the MAG House of Delegates it was voted to approve the matter of the Association Treasurer becoming an elected officer with voting membership on the MAG Council. It was further voted that all the necessary amendments to accomplish this objective should be published in the *JMAG* prior to May, 1972. The following amendments to the MAG Constitution and Bylaws to accomplish the above purposes have been approved by the Council and will be presented to the 1972 House of Delegates meeting for ratification:

A. Amendments to the Constitution

1. Amend Article V., Section 1, of the Constitution by deleting from the third line of the present Section 1 the word "Treasurer." Section 1 of Article V. as amended will then read as follows:

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component county medical societies as provided in the Bylaws. The officers, the Past Presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

2. Amend Article VI., Section 1, by inserting in the third line thereof between the word "Secretary" and the word "Speaker" the word "Treasurer." Also delete the words "the Treasurer" in line 4.

Section 1 of Article VI. as amended will then read as follows:

SECTION 1. COMPOSITION. Council is composed of the President, the President-Elect, the Immediate

Past President, the two preceding Immediate Past Presidents, two Vice-Presidents, Secretary, Treasurer, Speaker of the House of Delegates and Councilors as provided by the Bylaws. Delegates to the AMA, the Editor of the *Journal* and the Executive Director shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

3. Amend Article IX., Section 1, by inserting in the second line thereof between the word "Secretary" and the word "the," the words "the Treasurer."

Section 1 of Article IX. as amended will then read as follows:

SECTION 1. DESIGNATION. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Councilors and Vice-Councilors as provided for in the Bylaws.

4. Amend Article IX., Section 4, by inserting in the second line thereof between the word "Secretary" and the word "Speaker" the words "the Treasurer."

Section 4 of Article IX. as amended will then read as follows:

SECTION 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, the Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates and the Councilors and Vice-Councilors, who

shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

B. Amendments to the Bylaws

1. Amend Chapter IV., Section 1, first paragraph, of the Bylaws by inserting in line 3 thereof between the word "Secretary" and the word "Speaker" the word "Treasurer." The first paragraph of Section 1 of Chapter IV. as amended will then read as follows:

SECTION 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President who shall serve as a full member of Council for a period of 3 years, two Vice-Presidents, Secretary, Treasurer, Speaker of the House of Delegates or Vice-Speaker of the House of Delegates and Councilors or Vice-Councilors selected as follows:

2. Amend Chapter IV. Section 1, last paragraph, by deleting from the next to last line of said paragraph the words "the Treasurer." The last paragraph of Section 1 of Chapter IV. as amended will then read as follows:

Vice-Councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective Councilors, when they shall serve as Councilors. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker, when he shall serve in the Speaker's stead. Delegates to the American Medical Association, the Editor of the *Journal*, and the Executive Director shall be ex-officio members of Council without the right to vote.

3. Amend Chapter IV., Section 3, by inserting in line 4 thereof between the word "Secretary" and the word "the" the words "the Treasurer." Section 3 of Chapter IV. as amended will then read as follows:

SECTION 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the organization meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the First Vice-President, the Secretary, the Treasurer, the Chairman of Council, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. The Second Vice-President and the Speaker of the House of Delegates, or in his absence, the Vice-Speaker, shall be ex-officio, non-voting members of the Executive Committee. The Executive Committee shall meet monthly between meetings of Council. At any duly called meeting of the committee for which proper notice has been given, any three (3) members of the Committee shall constitute a quorum. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it. The Executive Committee shall appoint all Association Committees, including chairmen, and shall nominate members for all Boards required by the laws of the State of Georgia on recommendation of the district societies where applicable, not otherwise provided for, subject to confirmation by Council and shall serve as Publications Committee of the *Journal*. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive

Director who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee between meetings of Council shall have the authority and power of Council in the field of legislative activity. The Executive Committee shall act as Board of Trustees directing the Executive Director in carrying out the mandates and policies of the Council and the House of Delegates. Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Director as to undetermined matters of policy.

4. Amend Chapter V., Section 1, line 3, by inserting therein between the word "Secretary" and the word "the," the words "the Treasurer"; also amend line 8 by inserting between the word "Secretary" and the word "and," the words "the Treasurer"; also amend the next to the last line of same section by inserting therein between the word "Secretary" and the word "or," the words "or Treasurer." Section 1 of Chapter V. as amended will then read as follows:

SECTION 1. OFFICERS AND TERMS OF OFFICE. The officers of the Association are the President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. The Second Vice President shall be elected annually and shall become First Vice President at the time of the next Annual Session. The Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Councilors and Vice-Councilors shall serve for terms of three years. Delegates and Alternate Delegates to the American Medical Association shall serve in accordance with the Constitution and Bylaws of the American Medical Association and shall be elected in accordance with provisions of these bylaws consistent therewith. All other officers shall serve for one year. No member shall hold the office of Secretary, or Treasurer, or Speaker of the House of Delegates more than two consecutive terms.

5. Amend Chapter V., Section 2 by deleting the words "and of" in the second line and inserting the word "Treasurer" between the words "Secretary" and "Delegates."

6. Amend Chapter VI., Section 4, of the Bylaws by adopting a new sub-section 4(B), and redesignating the present subsection 4(B) as subsection 4(C). The new subsection 4(B) shall read as follows:

SECTION 4. TREASURER. (B) The Treasurer shall be a member in good standing for at least three years prior to his election and may not be the same member who holds the Office of Secretary. He shall be an officer of the Association and a voting member of the Council and of the Executive Committee of Council. He shall be an ex-officio member without the right to vote of the House of Delegates. The Treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Association.

7. Amend Chapter VIII. of the Bylaws by deleting the present Section 1, and then renumbering the present Sections 2 and 3 as Sections 1 and 2 of Chapter VIII.

It would appear from the author's experience that both of these agents are effective as alternatives to penicillin in the control of these infections.

A Comparison of Clindamycin and Erythromycin in Beta-Hemolytic Streptococcal Infections

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Synopsis-Abstract

Clindamycin and erythromycin estolate were compared bacteriologically and clinically in a double-blind randomized study using 107 children with Group A, beta-hemolytic streptococcal throat infections. Cultures were taken pre-treatment, during therapy, at the end of 10 days of therapy and 10 to 21 days after termination of therapy. Of the evaluable patients—47 on clindamycin and 52 on erythromycin—the clinical cure rate was similar although a trend was present in favor of clindamycin. Post-treatment cultures demonstrated no significant difference between the two drugs. There were no side effects and all patients recovered uneventfully. The investigators concluded that clindamycin is as effective as erythromycin estolate and both are satisfactory alternatives to penicillin in these common streptococcal infections of the upper respiratory tract.

THE GOALS OF ANTIBIOTIC THERAPY in Group A streptococcal infections are to eradicate the organisms, achieve prompt clinical improvement, prevent suppurative complications and to eliminate the antigenic stimulus felt to be responsible for the non-suppurative complications of rheumatic heart disease and glomerulonephritis. Penicillin is generally regarded as the drug of choice in meeting these goals.^{1, 2} However, because allergic reactions often are a problem and also since there is a recurrence rate of about 20 per cent when penicillin G or V is administered orally for 10 days,^{1, 3} other antibiotics are being used as alternatives. Among these, erythromycin stands out as one of the best—it is effective and is responsible for few side effects.⁴⁻⁶ The only reported serious complication to erythromycin therapy is reversible hepatotoxicity.⁷ Controlled studies to reject or confirm these retrospective reports have not been performed.

Another antibiotic, which has shown considerable promise in a variety of infections, is clindamycin (Cleocin®). It has been under intense clinical investigation for several years, and will soon be available for general use. This report gives the results of a controlled study to compare the efficacy and re-

currence or relapse rates of erythromycin estolate (Ilosone®) and clindamycin in the treatment of Group A, beta-hemolytic streptococcal throat infections.

Since the pharmacology, indications and dosage of erythromycin estolate are available in standard texts, we will summarize the pertinent data on clindamycin only.

Clindamycin

Clindamycin is produced by a chemical substitution of the 7(R)-hydroxyl group of the parent compound lincomycin.⁸ In a study conducted in healthy, fasting children, weighing 72 to 85 pounds and administered 8 mg/kg/day, it was shown that clindamycin was rapidly absorbed, peak serum levels occurring at 0.6 hours and the mean peak average was 2.56 mcg/ml.¹⁸ Serum levels following multiple doses of clindamycin for up to 14 days show no accumulation or altered drug metabolism. It is presently available as hard-filled capsules for oral administration. The drug is highly active against gram-positive organisms but has little activity against most gram-negative strains.¹¹⁻¹⁶ Concomitant administration of food does not adversely affect the amount absorbed. Serum levels are above the *in vitro* minimum bactericidal concentrations for most susceptible organisms for at least six hours following the usual recommended doses. The organisms sensitive to clindamycin *in vitro* include staphylococci (including penicillinase producing and methicillin-resistant strains), *Streptococcus viridans*, *Streptococcus pyogenes*, *Diplococcus pneumoniae*, *Clostridium* spp., *Corynebacterium diphtheriae*, *Bacteroides* spp., *Actinomyces* spp., and *Mycoplasma pneumoniae*.⁹ The antibiotic is not active against *Streptococcus faecalis*. Clindamycin has been well tolerated by healthy volunteers in doses of 2 gm a day for 14

TABLE I
SIGNS AND SYMPTOMS DURING THERAPY

Evaluation Period	Sign or Symptom	Clindamycin					Erythromycin				
		Abs.	Mild	Mod.	Sev.	Present	Abs.	Mild	Mod.	Sev.	Present
Pre-treatment	Sore throat	5	32	10	—	42	4	30	14	4	48
During treat.		40	6	1	—	7	37	14*	—	—	14
End of ther.		45	2	—	—	2	47	5	—	—	5
Pre-treatment	Fever	10	24	13	—	37	6	30	13	3	46
During treat.		43	3	1	—	4	44	7*	—	—	7
End of ther.		46	1	—	—	1	52	—	—	—	—
Pre-treatment	Enlargement of anterior cervical nodes	22	15	6	4	25	29	14	6	3	23
During treat.		38	8	1	—	9	43	7*	1	—	8
End of ther.		45	2	—	—	2	51	1	—	—	1
Pre-treatment	Scarlet fever rash	40	4	3	—	7	47	2	3	—	5
During treat.		40	1	—	—	1	49	2*	—	—	2
End of ther.		47	—	—	—	—	52	—	—	—	—
Pre-treatment	Nasal speech without rhinorrhea	44	2	—	—	2	51	—	1	—	1
During treat.		42	2	—	—	2	45	6*	—	—	6
End of ther.		46	1	—	—	1	51	1	—	—	1

* Not recorded for 1 patient.

days. Side effects thus far reported are limited chiefly to mild gastrointestinal complaints. The recommended pediatric dosage in mild to moderately severe infections is eight to 16 mg/kg/day divided into three or four equal doses. In severe infections, the dosage may be increased to 20 mg/kg/day.

Study Design

The study population consisted of 107 children with proven Group A beta-hemolytic streptococcal throat infections. The ages ranged from one to 16 years and the minimum body weight was 15 lbs. All of the patients had a sore throat and a positive culture—at least 10 per cent of the colonies were typical for Group A beta-hemolytic streptococci. In addition, each patient had at least three of the following acceptable clinical signs:² (1) fever, (2) marked redness or edema of the oral pharynx, (3) pharyngeal or tonsillar exudate, (4) petechiae with redness of the oral pharynx, (5) enlarged, tender anterior cervical nodes, (6) scarlet fever rash, and (7) nasal speech without rhinorrhea. Patients were assigned randomly on a double-blind basis.

Fifty-four patients were started on clindamycin and 53 on erythromycin. In order to maintain the double-blind nature of the study, the dosages administered were based on the recommended dosage for clindamycin. The duration of therapy was 10 days for all patients. For some of the younger children, it was necessary to open the capsules and give the medication in orange juice or with honey to facilitate acceptance.

125 mg of erythromycin was considered to be equivalent in activity to 75 mg of clindamycin for

the purposes of this study.

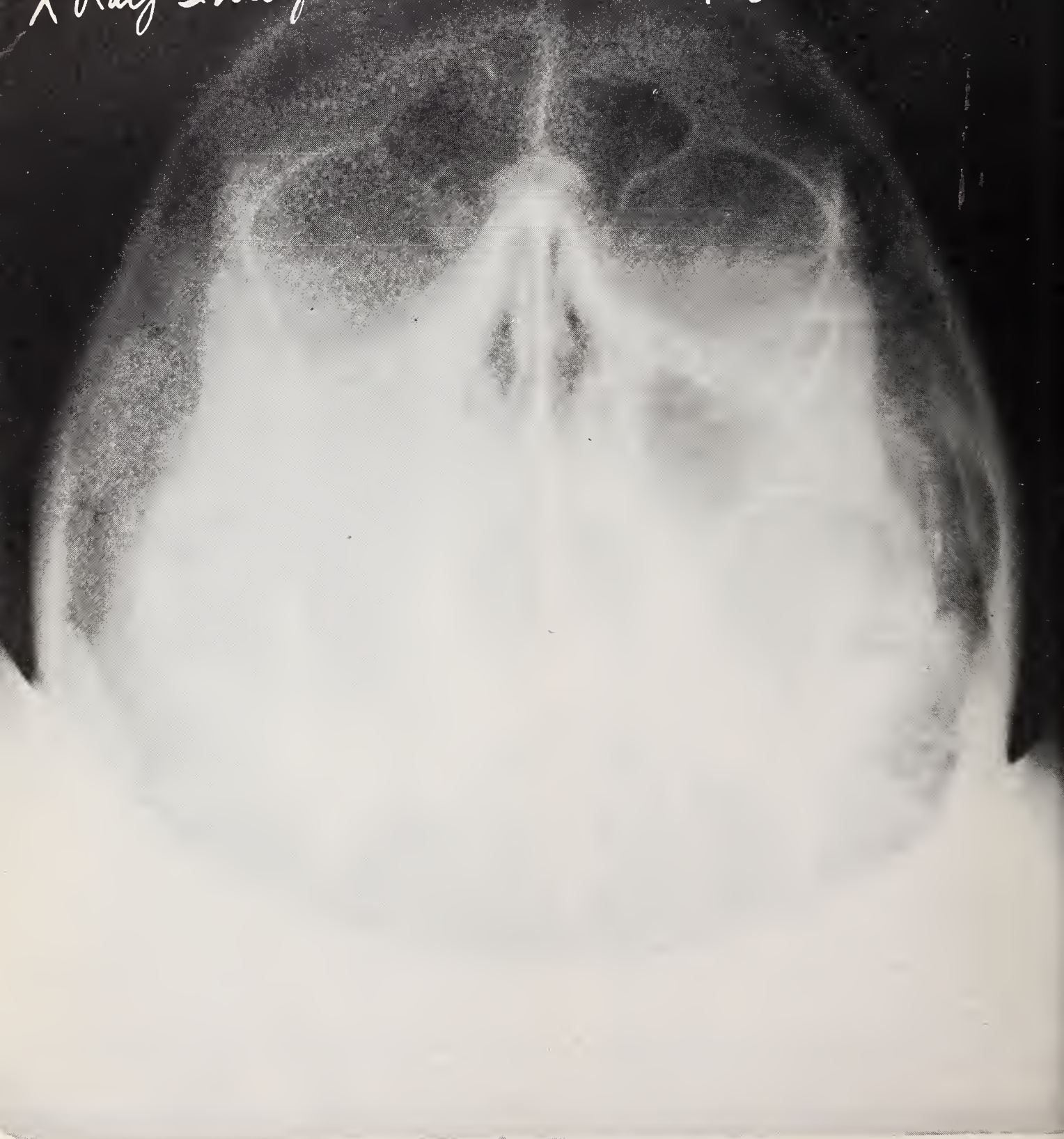
The patients were evaluated clinically and bacteriologically before therapy, during therapy, at the end of the therapy and at follow-up, 10-21 days after termination of therapy to determine bacteriologic relapse. While the duration of therapy was always 10 days, a few of the patients were evaluated earlier or later if the last day came on a weekend. Throat cultures were taken at each of these evaluation times. WBC counts, differentials and urinalyses were performed before therapy and at the end of therapy for each patient.

Data to determine clinical response were obtained from physical findings at the evaluation periods and from the answers to a fixed set of questions by the parents 18 to 72 hours after the onset of therapy. These questions concerned disappearance of fever, soreness of throat, size and tenderness of anterior cervical glands, nasality of voice in the absence of rhinorrhea, disappearance of scarlatiniform rash, and general disposition.

Results

Eight patients were removed from the study for the following reasons: three patients from the clindamycin group and one from the erythromycin group would not accept medication (capsules had been opened); the initial cultures from two patients were not Group A, beta-hemolytic streptococci; one patient developed enuresis while taking clindamycin and one patient's name was confused with another. The clinical and statistical analyses are therefore based on 47 patients in the clindamycin group and 52 in the erythromycin group.

CC: Pain on Rt. side of face
Dx: Acute purulent bacterial Max. Sinusitis
X-Ray Interp: Waters - Clouding of Rt. Max. Sinus



Age, sex, race, height and weight/dose were analyzed by the χ^2 method and there were no statistically significant differences between the two treatment groups. Two patients on clindamycin and six on erythromycin had a history of allergic disease such as hay fever and asthma. There was no significant difference between the two drugs as far as the clinical response was concerned. All patients in both groups were clinically well at the 3rd evaluation period—20-21 days from beginning therapy.

Table I gives the decrease in signs and symptoms of Group A, beta-hemolytic streptococcal throat infections during therapy. There were no statistically significant differences between groups for any of these signs and symptoms.

Table II shows the results of the initial and follow-up cultures. While there is no statistical significance, there is, however, a trend indicating more Group A, beta-hemolytic streptococci in the follow-up cultures in the erythromycin group.

The hematologic findings were similar for both groups. There were no side effects reported in either treatment group and all patients recovered without complications.

Discussion

Because a pediatric formulation was not available when this study was conducted, it was necessary to open the capsules for some of the smaller children. Unfortunately, clindamycin has a bitter taste that is difficult to disguise. Therefore, it is not surprising that three of the patients on clindamycin refused medication and were dropped from the study.

The two groups were very similar in terms of demography and the signs and symptoms of Group A, beta-hemolytic streptococcal infection. The decrease in signs and symptoms was earlier in the clindamycin group at the evaluation conducted during therapy, although the difference was not statistically significant. Both antibiotics produced clinical cure. There were no side effects in either treatment group and all the patients recovered uneventfully. There were fewer bacteriologic recurrences in the clindamycin group (5/44-11.3 per cent) than in the erythromycin group (7/46-15.2 per cent). Recurrences were lower than those for penicillin as reported in the literature. Although the trend seemed to favor clindamycin, the number of patients was too small to demonstrate statistical significance.

The results of an uncontrolled study we conducted on the efficacy of clindamycin in BHS infections was recently published.¹⁷ This present report simply confirmed the impression gained from our previous clinical experience. We conclude that clindamycin is as effective as erythromycin estolate and both are satisfactory alternatives to penicillin in these com-

TABLE II
CULTURE POSITIVE FOR GROUP A,
BETA-HEMOLYTIC STREPTOCOCCI

Evaluation Period	Clindamycin 47 Pts.	Erythromycin 52 Pts.
Pre-treatment	47/47 (100%)	52/52 (100%)
During therapy		
(2-6 days)	0/47 (0%)	3/52 (5.8%)
End of therapy	0/43 (0%)	2/52* (3.8%)
Post therapy		
(10-21 days after therapy terminated)	5/44 (11.35%)	7/46 (15.21%)

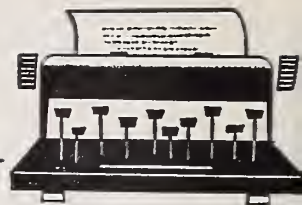
* One patient with positive end of therapy culture had a negative culture at the follow up.

mon streptococcal infections of the upper respiratory tract.

6500 Vernon Woods Dr., N.E.

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Welcome to Macon

ON BEHALF OF THE BIBB COUNTY MEDICAL SOCIETY, may I extend to you the warmest welcome to the 118th annual session of the Medical Association of Georgia which will meet in Macon on May 11-14.

Although we still claim the warmth and easy accessibility of the small town, we believe you will love our many elegant hotel and motel facilities, smart shops, and unusual dining spots. Historically, we can offer much in the Ocmulgee National Monument, Hay and Cannon Ball Houses, and the Sidney Lanier Cottage, to mention a few. Our Museum of Arts and Sciences, new Coliseum, and our splendid colleges and universities are sources of pride. We have added a new hospital and new additions are almost finished on all the hospitals since your last visit in Macon. A self-guided Heritage Tour is available through the Chamber of Commerce Office.

Special art exhibits, an antique car show, and special sporting events should have something of interest for everyone. The interstate highways empty into the center of town, making us within easy driving range.

Finally, we extend you a special welcome to the Bibb County Medical Society Social Hour on Saturday P.M., May 13. We are all anxious to make your stay pleasant—call on any of us—“What can we do for you?”

L. E. Dickey, M.D.

President of Bibb County Medical Society

Prostaglandins

THE PROSTAGLANDINS, a family of compounds endogenous to the animal kingdom, possess potent biological activities that rival norepinephrine and the steroids in their diversity. A potentially important but poorly defined physiological role and their tremendous therapeutic potential has stimulated extensive research on the prostaglandins in recent years with considerable resultant publicity in the lay and scientific press.

The term prostaglandin, a relative misnomer, arose from the observations by von Euler and Goldblatt in the 1930's that a lipid material, present in semen and seminal tissues, exerted potent contractile effects on uterine smooth muscle. These compounds are now known to be 20 carbon, unsaturated hydroxy fatty acids characterized by a cyclopentane ring at C₈-C₁₂. Two primary prostaglandin types (PGE and PGF) and a third important derivative (PGA) differ only in the oxygen and hydrogen atoms present at the C₉ and C₁₁ positions. Sub-types are further defined by the number of side chain double bonds; e.g., PGE₁, PGE₂, and PGE₃. Biosynthesis of prostaglandins from essential fatty acids occurs in most tissues and can be induced by mechanical stress, neural stimulation and a variety of hormones. Metabolism to partially or totally inactive compounds occurs rapidly, with the lung and liver being particularly effective for the breakdown of circulating prostaglandins.

Effective prostaglandin biosynthetic preparations and a total chemical synthesis have made a variety of prostaglandin compounds available for pharmacological testing. Most prostaglandin biological actions are type and species specific and appear to be direct; i.e., they do not involve neural reflex activation or the re-

lease of other endogenous compounds. The array of prostaglandin pharmacological effects includes: vasodilatation and positive cardiac inotropism and chronotropism; natriuretic and diuretic renal actions; type specific actions on platelet aggregation, reduction of gastric acid secretion and increased gastric and intestinal motility; increased uterine and tubal motility and tone, luteolysis, and increased sperm motility; bronchial dilatation; miosis and increased intraocular pressure; an antilipolytic action; and important interactions with a number of hormones.

Physiological Role

The physiological role of prostaglandins remains a challenging biologic puzzle. In view of their ubiquitous distribution, rapid metabolism and diverse activity, prostaglandins do not appear to be hormones in the classic sense but may rather serve as important local metabolic and vascular regulator substances. An appealing hypothesis proposes that prostaglandin synthesis occurs in the phospholipid portion of cell membranes as required for the control of certain membrane functions and for the modulation of neural and hormonal "messenger traffic" across the cell membrane. A number of prostaglandin actions on cellular calcium kinetics and on intracellular cyclic-AMP ("second messenger") activity have been demonstrated and these findings lend support to the stated hypothesis. In addition, the prostaglandins may play an important role in the pathology of inflammatory responses to trauma or infection through the mechanisms of vasodilation, altered vascular permeability, and local metabolic alterations. Recent reports may in part explain the anti-inflammatory effect of aspirin by the demonstration of an aspirin inhibitory action on prostaglandin synthesis.

Two major factors have impeded the efforts of investigators to better define the physiological and pathological roles of prostaglandins. First, prostaglandin assay is difficult, time consuming and expensive, although recent advances in chemical separation and in the radio-immunoassay technique promise to implement the analysis of blood and tissue prostaglandins; and secondly, an effective pharmacologic blocking agent for *in vivo* prostaglandin activity is not available.

Clinical Applications

Many clinical applications for the prostaglandins have been suggested and a number of clinical trials are underway at present. Considerable experience has been acquired in the use of prostaglandins for the induction of both labor and abortion. The intravenous and intravaginal administration of prostaglandins appears to produce effective uterine contractions of a physiological type without deleterious effects to mother or fetus. At present the use of prostaglandins for the induction of abortion in the first trimester of pregnancy does not appear to offer an improvement over existing techniques, whereas the available data suggests that their use for second trimester abortion may be the method of choice. The administration of prostaglandins for the purpose of birth control is an exciting but relatively unexplored application.

The potent, direct vasodilator activity of certain prostaglandins coupled with their natriuretic and diuretic properties may prove useful as anti-hypertensive therapy in acute situations, particularly in the presence of heart failure. Long term anti-hypertensive therapy with prostaglandins will depend on the development of an oral preparation free from deleterious side effects. Additional areas of therapeutic interest include the use of prostaglandins as bronchodilators, as nasal decongestants, and for the control of gastric acidity in the therapy of peptic ulcer disease.

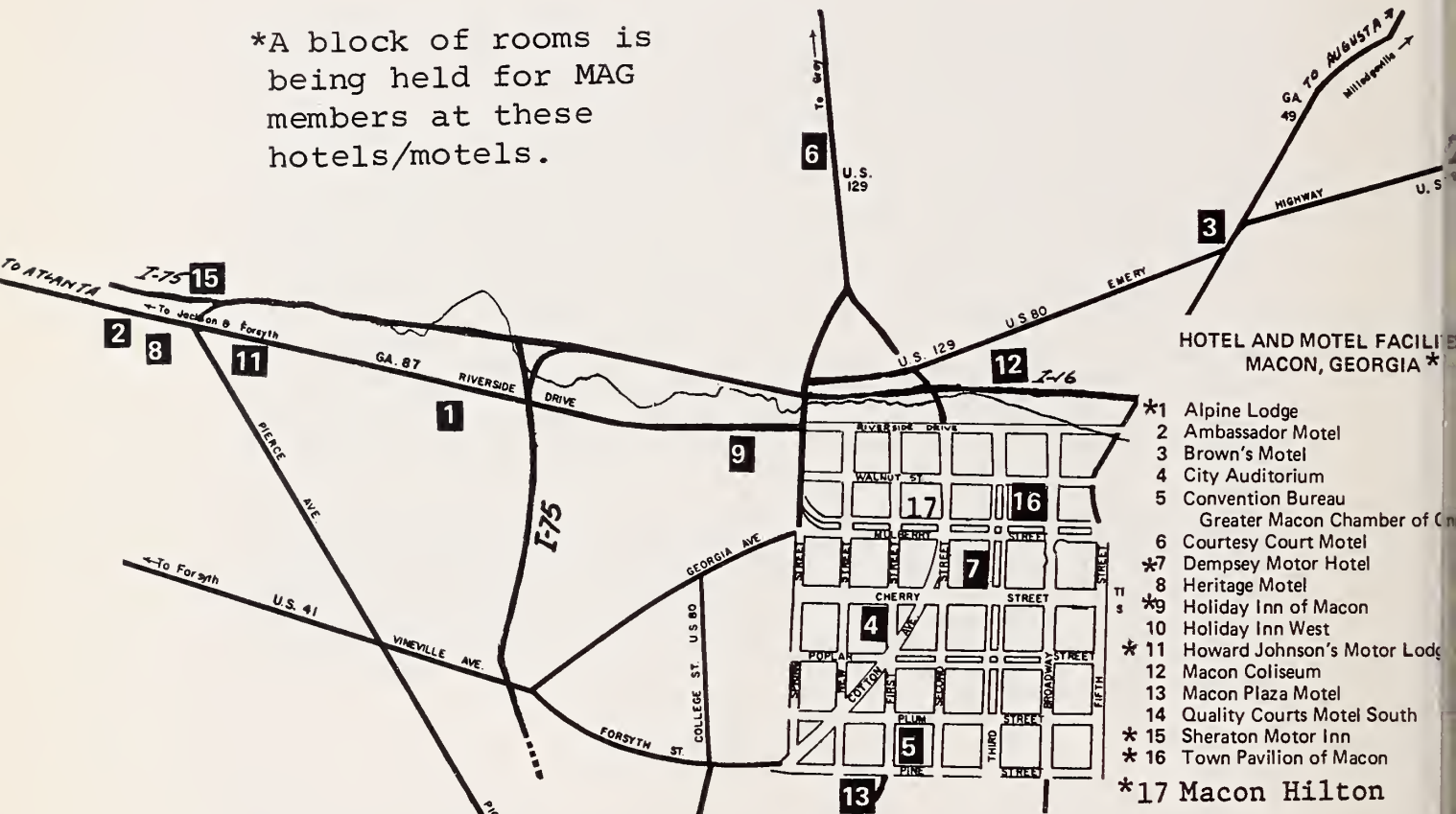
Continued basic and clinical research in prostaglandin physiology and pharmacology will hopefully answer the many questions of vital interest posed by these unique compounds.

*Donald O. Nutter, M.D.
Emory University School of Medicine, Atlanta*

1972 Annual Session

LOCATION OF HOTELS AND MOTELS IN MACON

*A block of rooms is being held for MAG members at these hotels/motels.



THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 11, 1972

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 12, 1972

- 9:00 a.m.—First General Session
First Session, House of Delegates
Featured Speaker: "Government Controlled Medical Care"
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Health Care Delivery Systems—Past, Present and Future"

6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 13, 1972

- 9:00 a.m.—Reference Committee Meetings
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Venereal Disease," "Sex in Schools" and "Dynamics of Violence"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 14, 1972

- 7:00 a.m.—Prayer Breakfast
- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia

Annual Session

May 11-14, 1972—Macon, Georgia
RESERVATION REQUEST

- 1. Please complete this form and mail to: Reservation Department
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- 2. Special reservation forms will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
- 3. Assignment of rooms will be made in order of receipt of reservation. If possible confirmation will be in accordance with preference indicated; if not, best substitute will be made.
- 4. Unreserved accommodations will be released on April 20, 1972.
- 5. Rooms will not be ready for occupancy until 2:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.
- 6. A quick check out card will be placed in each room at the Macon Hilton Hotel. Turn this in at Registration Desk and you will be billed later.

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Dempsey Motor Hotel P.O. Box 127, Macon, Ga. 31202	Single—\$10.00-14.00 Double—\$16.00-20.00	\$3.00 \$3.00
Holiday Inn of Macon 1044 Riverside Dr., Macon, Ga. 31202	Single—\$13.50 Double—\$16.00	
Howard Johnson's Motor Lodge 2566 Riverside Dr., Macon, Ga. 31202	Single—\$13.00-16.00 Double—\$18.00-21.00	\$3.00 \$3.00
Macon Hilton Hotel P.O. Box 144, Macon, Ga. 31202	Single—\$17.00 Double—\$23.00	\$6.00 \$6.00
Sheraton Motor Inn 2737 Sheraton Dr., Macon, Ga. 31202	Single—\$12.00-16.00 Double—\$15.00-19.00	\$3.00 \$3.00
Town Pavilion Motel Broadway at Walnut Street, Macon, Ga. 31202	Single—\$10.00-11.00 Double—\$13.00-14.00	\$3.00 \$3.00

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MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION
MAY 11-14, 1972

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RIDE IT HARD

I AM SURE there is not one among you who does not have some favorite pastime that he enjoys losing himself in when he feels he must get away from the pressures of responsibility that go along with the everyday push and grind of the practice of medicine. Sir William Osler said, "No man is really happy or safe without a hobby, and it makes precious little difference what the outside interest may be—botany, beatles, or butterflies—anything will do so long as he straddles a hobby and rides it hard." The dictionary says it is an interest, occupation, or activity engaged in primarily for pleasure. There are others who say it is something one goes nuts over to keep from going nuts. No matter which definition you prefer, it does give one a freedom from responsibility and availability and a chance to do one's own thing. Seldom does it involve much mental challenge, but it does allow one to leave the crowd and the phones behind and along the way you could pick up the refreshing associations of some non-medical people. To be taken completely out of the world of medicine is far cheaper than psychiatry and it is an easy way to get a recharge in your battery. Whatever you do in your so-called after hours or leisure time I'm sure needs no apology, and so long as it is "legit" it's bound to keep you more refreshed and better able to tackle your day-to-day problems. So, along with Dr. Osler, I say stick with it and "ride it hard."

Being in solo practice, having other outside interests along with trying to make good as President of MAG this year by participating as near as possible in all the activities required of a president, would seem to cut me a little short in hobby time. But, feeling as I do—that the hobbies help to make the other things easier and more enjoyable—I have still found some time for them.

Presidential Hobby

My particular yen is for history and anything connected with the Civil War, along with a crazy obsession to collect items that others would consider worthless. Items that would be lost to future generations unless someone took the time to find and preserve them. As an investment, my collectibles would be rated 'way down the list by those who ride their hobby with a profit in mind, but it's fun and relaxation to me and I like and enjoy it and, after all, that's what a hobby is for. Just what do I collect mostly?

(1) Confederate Money—some 10 to 15 thousand dollars' worth. (That is, what it was worth in 1861-1864.) I have at least one of nearly every type bill issued.

(2) TB Christmas Seals—at least one of every one issued in the U. S. since the idea started (1907) and foreign TB Christmas seals from some 60 of the nearly 100 countries that have issued them. Most of them are beautiful and usually depict something that is characteristic of the country of their origin. Many of the countries are no longer in existence, and the names of some of the others will make you reach for your world atlas. Can you think of anything crazier to prize and collect to keep from going crazy?

(3) Political Campaign Buttons—some go back to Lincoln. Some folks would like to forget old political campaigns but this would not make them so. If it were possible to forget the campaigns and the politicians, maybe there are a few we are stuck with at the present time we would like to blot out.

This gives you some idea just how you can get involved. You really don't have to be crazy to do it, but I'll admit it does help.

I believe it would be a good feature for the *MAG Journal* to have a "Hobby Page," and each month those who cared to could share their experiences and this page might be a medium of helping others in getting started, or swapping something you have for something you have been looking for and unable to find, or just exchanging ideas.

Did you realize that come next month—that is, with the May issue of the *Journal*—you will no longer have to read the President's Page coming from me and you will have a new face to look upon? Maybe after all this you have just read, you'll be glad. You know there are still just two sure things in life—death and taxes—and both of them leave you in a hole.

See you next month.

W.C. Mitchell

W. C. Mitchell, M.D.

President, Medical Association of Ga.

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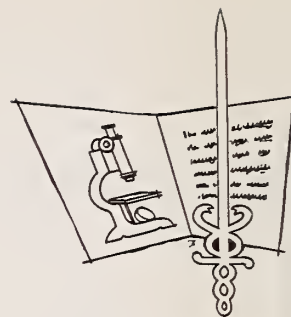
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CANCER DETECTION

S. ANGIER WILLS, M.D., F.A.C.S., *Decatur*

UNTIL A CURATIVE THERAPY for metastatic carcinoma is available, it is necessary that members of the medical profession direct their attention to those practical measures that will allow the early detection of malignant tumors. In that yet to be defined segment of the population whose tumors remain either localized or in a reversible state and can be benefitted by early detection of their tumors, lies the challenge to the practicing physicians to find these lesions as soon as possible.

The first requirement for such a program depends upon the patient understanding the need for such a periodic investigation and his willingness to present himself for such an investigation. Given the Utopian situation in which the population will do this, the uncomfortable problem that still exists is that cancer is a silent disease and that by the time the patient is aware of an abnormality we are in truth dealing not with early cancer but with late cancer. For example, by the time an ordinary breast cancer has reached the size of two and one-half centimeters it has already gone through three-fourths of its life history in terms of its doubling time and metastatic potential.

However, it would be unreasonable to stay immobilized waiting for the invention of a diagnostic tool for the revealing of early malignant cells. So at the present time we direct our attention to that undefined number of malignant tumors that may still be influenced by therapy today and not tomorrow.

Search for Tumors

Now if the greatest number of these tumors are to be discovered then every opportunity must be exploited to find them. This must be done by the practicing physicians in this country when the patient presents himself within the confines of his office. There are a couple of favorable observations that make this endeavor appear rewarding. One half of all carcinomas are at some directly accessible site. In the female, 22 per cent of her tumors will be in the breast, another 19 per cent in the uterus; 5 per cent will be in the colo-rectal area, 2 per cent in the oro-pharynx, 1 per cent in the thyroid and 11 per cent on her skin. In the male, 16 per cent will be of the skin, 10 per cent of the prostate, 7 per cent of the colo-rectal site, $\frac{1}{2}$ of 1 per cent of the thyroid and $6\frac{1}{2}$ per cent of the oro-pharynx. These areas are relatively easy to examine in any physician's office in a relatively short period of time. The use of the chest x-ray and gastrointestinal studies add several more tumor group sites in the survey of the patient.

Another observation is that 75 per cent of the carcinomas occur in relatively favorable sites for cure. Seventy-five per cent of the carcinomas will occur in the colon, rectum, ovary, testes, bladder, skin, salivary glands, breast, thyroid, cervix, oro-pharynx, soft tissues, larynx, lip and skin.

These are the patients that may well be detected earlier by our still primitive means of looking for cancer, and by the observations made previously, one may hopefully expect to lower to an appreciable degree the present day mortality rate

from cancer. To illustrate this point only one form of cancer need be mentioned, the form that is most common in men and women combined. Deaths from carcinoma of the colon and rectum total about 46,000 a year in the United States. The number of new cases reported annually is about 73,000. This is a lesion in which 75 per cent of the tumors can be examined directly and the other 25 per cent by a relatively adequate indirect examination. Our present state of knowledge allows us to treat late cancers in this region with a survival rate of about 40 per cent. In isolated studies, however, the salvage rate can be as high as 75 per cent still using rather primitive means of uncovering the disease. This type of observation can be made in several other cancers and has been adequately demonstrated in what has been done in lowering the mortality rate from carcinoma of the cervix by the early detection of that disease—the pap smear.

Opportunity for Detection

The object of making the above observations is for the purpose of pointing out that the detection of cancer in our still rather primitive way can be carried out in every physician's office if he thinks in terms of those areas that he can examine adequately and of those tumors which can still be curable. If he will think in these terms, regardless of his specialty, and regardless of what he may have thought previously of the time required for such examinations, he can adequately screen many patients that come across his office threshold.

It is in this stop-gap fashion that we physicians of today can increase the cure rate in this disease until more adequate means are at our disposal for finding the true early cancer.

755 Columbia Dr.

DR. FINDLEY RETURNS TO GEORGIA

Dr. Thomas Findley, formerly Professor and Chairman of the Department of Medicine, Medical College of Georgia in Augusta until 1968, has recently returned to Georgia and has opened an office in Atlanta at 1938 Peachtree Road, N.W., for the practice of internal medicine.

It will be of interest to his former students and residents that he spent a year in Taiwan following his resignation from his post in Augusta. He served as Visiting Professor of Medicine in Taipei, the Republic of China. The next two years were spent in Knoxville, Tennessee with the Regional Medical Program in Ap-

palachia.

Private practice is not new to Dr. Findley, having practiced solo in St. Louis, Missouri for six years. Following this he did group practice as head of the Department of Medicine at the Ochsner Clinic and on the Tulane faculty. He is a Master and former Regent of the American College of Physicians. He at one time served as Secretary-Treasurer of the American Board of Internal Medicine. During his years as Professor of Medicine at the Medical College of Georgia he was very active as a contributing editor of the *Journal of the Medical Association of Georgia*.

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SICKLE CELL HEART DISEASE

JOHN H. WEST, M.D., *Savannah*

SICKLE CELL ANEMIA ranks with syphilis as one of the great masqueraders in the annals of medical history. This is particularly true in relation to the wide variety of cardiovascular findings that can be seen in homozygous sickle cell anemia (SS). Since Herrick first described the now classic features of sickle cell anemia in 1910, sickle cell heart disease has been confused with other types of heart disease. The long standing chronic hemolytic anemia is the basic pathophysiologic mechanism responsible for the cardiovascular findings. (Two other mechanisms seldom evoked are myocardial infarction and cor pulmonale.)

Cardiac dilatation and eventual hypertrophy result from the long standing increased work load of the heart required to compensate for the reduced oxygen carrying capacity of the blood. Consequently, cardiomegaly is seen in 95 per cent of the cases and cardiac murmurs are present in at least 75 per cent of these patients associated with a history of exertional dyspnea. Congestive heart failure is a rare and late manifestation and, if seen, is usually refractory to digitalis therapy. However, sickle cell patients frequently have arterial oxygen unsaturation which is not seen in other anemias. Possible explanations for this phenomenon are pulmonary venoarteriolar shunting, pulmonary diffusion defects and an abnormal oxyhemoglobin dissociation curve. Due to the variety of cardiovascular findings that may be present in sickle cell anemia, the diagnosis of associated rheumatic heart disease, congenital heart disease or coronary atherosclerotic heart disease is quite difficult. Fortunately, these diseases are associated so infrequently with sickle cell anemia that they are exceptionally rare.

Disease Characteristics

Typically in sickle cell anemia the cardiovascular examination reveals a slight tachycardia with a normal systolic blood pressure and a slightly reduced diastolic pressure. The precordium is active, a left parasternal lift is usually palpated and occasionally a systolic thrill can be felt over the pulmonary artery. A majority of patients will have either a systolic murmur at the second left intercostal space or at the apex or in both areas. These murmurs are related to increased blood flow and are not due to deformity of the valves. Congenital defects can be mimicked easily. The systolic murmur at the apex can suggest mitral insufficiency, and occasionally a presystolic rumble is heard simulating valvular mitral stenosis. A third heart sound in mid-diastole is common at the apex.

On chest x-ray, the cardiomegaly usually is of a globular type. A prominent pulmonary conus associated with increased pulmonary markings can give the x-ray picture of the "mitral heart"; however, upon lateral film or cardiac series in the sickle cell patient, left atrial enlargement will be absent. Fluoroscopy will reveal prominent pulmonary pulsations. Common EKG findings are prolongation of the P-R interval, non-specific ST and T wave changes, LVH with strain pattern, and incomplete right bundle branch block.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

In the majority of sickle cell patients, cor pulmonale can only be diagnosed with assurance by cardiac catheterization and documentation of pulmonary hypertension. A sickle cell patient in pain crisis with anemia, fever, joint pains, leukocytosis, cardiac murmurs and increased PR interval can simulate an episode of acute rheumatic fever. A few cases of documented acute rheumatic fever have been reported in association with sickle cell anemia, but this diagnosis is difficult to confirm unless the patient gets classical subcutaneous nodules or an episode of congestive heart failure during the acute episode. Likewise, in quiescent periods, the flow murmurs usually seen in sickle cell anemia can simulate the murmurs of chronic rheumatic heart disease. However, it is important to make the distinction between these two entities because of the availability of therapy in acute rheumatic fever and the necessity to prevent further episodes by antibiotic prophylaxis.

Angina pectoris is common in sickle cell patients and can be relieved by transfusion therapy. However, in sickle cell patients, post-mortem studies have commonly revealed no evidence of myocardial infarction. Isolated cases have been documented with coronary artery occlusion due to sickled red cell thrombi with resulting infarction of the myocardium. The typical findings of a sickle cell heart at autopsy are biventricular dilatation and hypertrophy with normal valves.

Thus, the many cardiovascular manifestations of sickle cell anemia comprise the syndrome of "sickle cell heart disease." If abnormal sickling can be demonstrated in the presence of cardiac disease, sickle cell heart disease is a likely diagnosis.

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THE INTRODUCTION OF SMALLPOX VACCINATION INTO THE UNITED STATES

As early as 1768, a dairymaid told Dr. Edward Jenner, an English physician, she could not take smallpox because she had previously had cowpox. After 28 years of observation, study and discussion, Dr. Jenner, on May 11, 1796, vaccinated a boy, James Phipps, with pus from the hands of a milkmaid, Sarah Nelms, who was in the active stages of cowpox. The experiment succeeded. He then tried to infect the child with pus from human smallpox. This was repeated many times, but the child was not susceptible to smallpox because he had received the protection from cowpox. Thus Dr. Jenner showed the value of vaccination in the prevention of smallpox.

Vaccination against smallpox was introduced in the United States by Dr. Benjamin Waterhouse, of Boston, on July 8, 1800, when he vaccinated his son Daniel, age 5 years. This vaccination was successful.

Waterhouse was a native of Newport, Rhode Island. At the age of 16, he was apprenticed to John Halliburton, a physician in Newport. Waterhouse went to England in 1775, on the last ship allowed by the British to leave Boston, and remained abroad until 1782. He received his M.D. degree from Heyden University in Holland, a popular medical school in Europe. After several years in Europe he returned to the United States and began the practice of medicine in Newport. Within a year he was invited by Harvard College to take the chair of medicine (theory and practice of physic) as one of three members of the faculty of the prospective medical school.

Dr. Waterhouse recognized the importance of Jenner's observations and immediately made plans to secure a supply of the vaccine matter. He vaccinated about 50 persons by the first of September, 1800.

On December 1, 1800, Dr. Waterhouse wrote to President Thomas Jefferson relative to "a prospect for exterminating the smallpox." Thomas Jefferson replied promptly, requesting some of the vaccine matter. Upon receiving the material, President Jefferson put this material in the hands of physicians and later supervised vaccinations within his family and household.

There are many who regard Thomas Jefferson as one of the outstanding scientists of his era. Through the efforts of Mr. Jefferson, an "Act to Encourage Vaccination" was passed by Congress and approved on February 27, 1813. This Act provided for the transmission through the mails, without cost, vaccine matter for vaccination against smallpox. Vaccination against smallpox in the United States having become well established, further assistance from the Federal Government appeared to be unnecessary. The "Act to Encourage Vaccination" was repealed, effective May 4, 1822.

When the Lewis and Clark expedition was organized by President Jefferson late in 1803 to spend more than two years exploring the vast lands to be purchased from France, he included in his instructions the following: "Carry with you some matter of the *kinepox*, inform those of them with whom you may be of its efficiency as a preservative from the smallpox, and instruct and encourage them in its use."

Ralph C. Williams, Sr., M.D.

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Wallace, Robert G. Active—Muscogee—R	P.O. Drawer 2787 Columbus, Georgia 31902

SOCIETIES

L. E. Dickey has been elected president of the **Bibb County Medical Society** for 1972. Other officers voted in at this time are J. P. Woodhall, vice-president; J. T. Hogan, president-elect; G. Wayne Bohannon, secretary-treasurer and Sam E. Patton, parliamentarian.

Earnest C. Atkins is the new president of the **DeKalb County Medical Society**, serving with Benjamin B. Okel, vice-president; John P. Heard, president-elect; L. L. Freeman, secretary-treasurer and Peter C. Sotus, corresponding secretary.

The **Georgia Medical Society** has elected Darnell L. Brawner as president for 1972, with Edwin C. Shepherd, vice-president; William H. Lippitt, president-elect; Harry H. McGee, Jr., secretary and Dearing Nash, treasurer.

Charles E. Todd has been installed as president of the **Medical Association of Atlanta**. Other new officers elected were Harrison L. Rogers, Jr., vice-president; Joseph L. Girardeau, secretary and L. Newton Turk, III, treasurer.

Members of the **Tift County Medical Society** have been asked to contribute \$200 each toward establishment of a fund to be used for offering rewards to persons giving information leading to the arrest and conviction of drug pushers.

PERSONALS

Second District

J. J. Collins, Sr., former chief radiologist at John D. Archbold Memorial Hospital, Thomasville, was honored at the Annual Meeting of the Board of Trustees of the hospital on the occasion of his retirement, due to ill health. Tributes were paid to Dr. Collins by Mr. Joe Higgins, president of the Board and Mr. Frank Eidson, Board member who presented Dr. Collins with a silver tray.

Third District

A. Gatewood Dudley has begun the practice of medicine in Americus, in partnership with T. Schley Gatewood and Richard B. Stewart.

Fifth District

Edgar Boling of Atlanta has been elected president-elect of the Southern Medical Association.

A. Hamblin Letton has been named president of the American Cancer Society.

H. Harlan Stone of Atlanta has co-edited a book on the problems of burns, entitled, "Contemporary Burn Management."

Sixth District

James C. Dismuke is moving his practice from Adel to Macon.

George T. Henry of Barnesville has been re-elected to active membership in the American Academy of Family Physicians.

Eighth District

Wiley B. Lewis of Waycross has been elected to active membership in the American Academy of Family Physicians.

Hart Sylvester of Hawkinsville has been named to the medical staff of Dodge County Hospital.

H. M. Edge of Blairsville retired from practice on December 13, 1971.

Ninth District

A. G. Funderburke, who practiced in Moultrie and Colquitt county for 36 years, announced his retirement in November, 1971.

Thomas N. Lumsden has been re-elected to active membership in the American Academy of Family Practice.

DEATHS

Joseph Davis Applewhite

Joseph Davis Applewhite, 80, died November 7, 1971, in a Macon hospital.

A native of Montgomery County, Mississippi, Dr. Applewhite was graduated with honors from Vanderbilt University Medical School in 1913, and later received a master's degree in public health at Harvard University.

He was a member of the American Medical Association, the American Public Health Association, Medical Association of Georgia, and Bibb County Medical Society. Dr. Applewhite was also a member of the American College of Physicians, former chairman of the public health section of the Southern Medical Association, first vice-president of both the Medical Association of Georgia and Georgia Tuberculosis Association, and president of the Clarke and Bibb County medical societies.

In 1964 he was named Practitioner of the Year by the Medical Association of Georgia and in 1966 was named Doctor of the Year by the staff of the Middle Georgia Hospital.

He is survived by his widow, two daughters, three brothers and a sister.

Cecil Brannen

Cecil Brannen died November 28 in Moultrie, following a lengthy illness. He was 71.

A native of Brantley, Alabama, he served in the Medical Corps during World War I and practiced in Miami and Bradenton, Florida, prior to moving to Moultrie in 1937.

Dr. Brannen was a member of Trinity Baptist Church, Hasan Temple of the Shrine, Elks Lodge, Masonic Lodge and the Moultrie Shrine Club.

He is survived by his widow, the former Ethel Morris of Moultrie; one daughter, Mrs. Becky Brannen Woodward, Jacksonville, Fla.; a brother, Dr. O. C. Brannen, Bradenton, Fla., and two grandchildren.

Ralph Newton Johnson

Ralph Newton Johnson died January 20 in a Rome hospital, following an extended illness. He was 66.

Dr. Johnson was born in Attalla, Alabama. He was a graduate of Mercer University and Emory Medical College, and was a member of the Floyd County Medical Society, Medical Association of Georgia and American Medical Association.

He was a fellow of the American College of Surgeons, a former member of the Rome Kiwanis Club, Coosa and Callier Springs Country Clubs, and a deacon and member of the First Baptist Church.

Dr. Johnson is survived by one daughter, Miss Barbara Olivia Johnson, Boulder, Colorado; a sister, Mrs. Alvin Everett, Rome and a brother, Dr. J. Glover Johnson, Williamstown, West Virginia.

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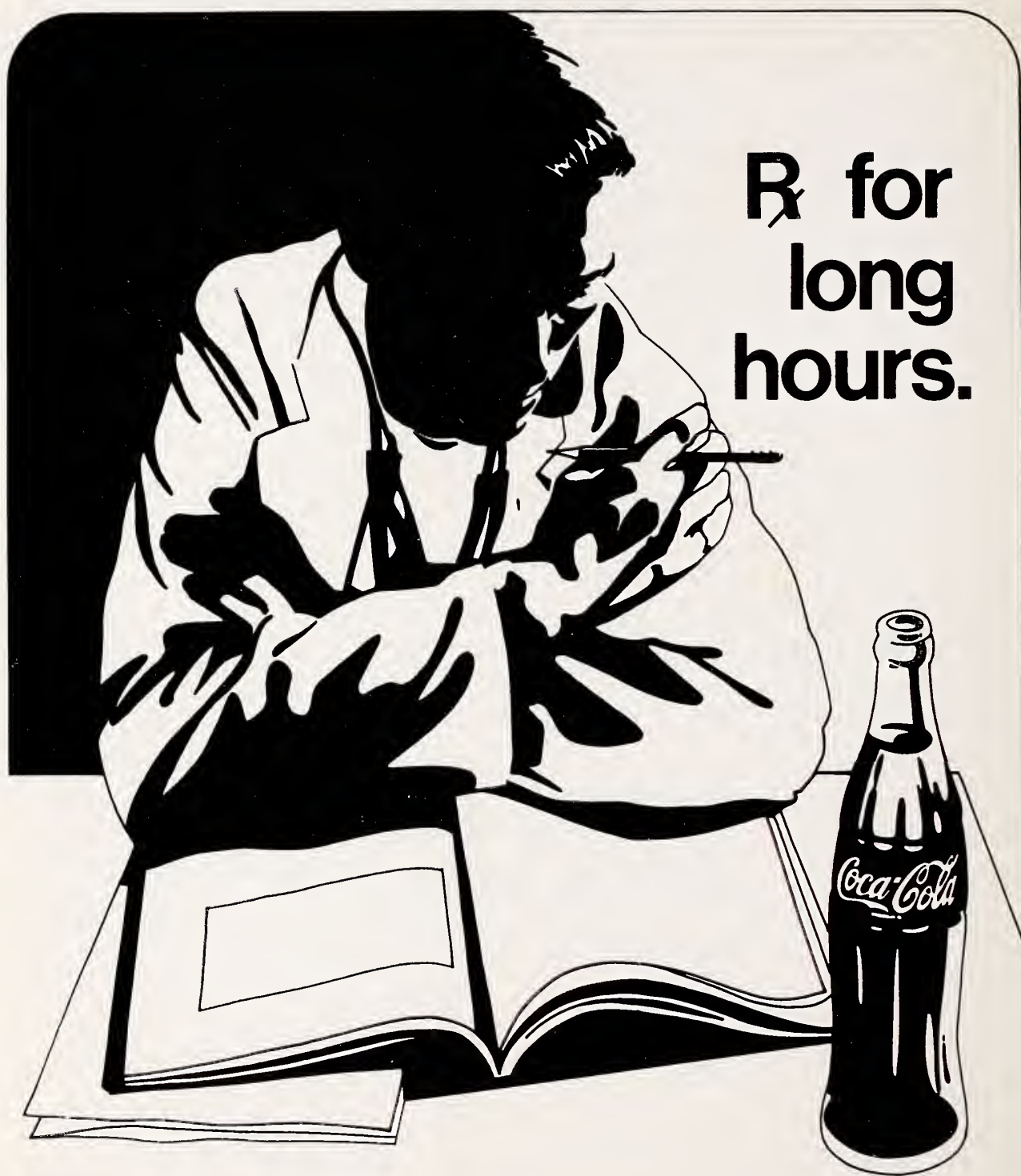
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Contents

Special Articles

MEDICAL EDUCATION—A DEVELOPING MODEL? J. Rhodes Haverty, M.D.	125
PRIMARY MEDICAL CARE: WHOSE RESPONSIBILITY? Robert E. Reynolds, M.D.	127
CONTINUING EDUCATION AND COMMUNITY HOSPITALS C. Daniel Cabaniss, M.D.	131
PHYSICIAN ASSISTANTS AND MEDICAL PRACTICE Harrison L. Rogers, M.D.	133

Editorials

THE ACCREDITATION PROCESS AS AN EDUCATIONAL TOOL Luther G. Fortson, M.D.	134
PHASE II EFFECTS ON PHYSICIANS	135

Features

Cancer Page	142
Heart Page	143
Legal Page	145
Month in Washington	148

The Association

President's Page	140
New Members	147
Personals	147
Deaths	147

Cover

Design by Robert Hamill, Atlanta.

Medical Education—A Developing Model?

J. RHODES HAVERTY, M.D., *Atlanta*

ONE OF THE PROBLEMS frequently identified today regarding the practice of medicine in the United States is the lack of primary care physicians—physicians who look on themselves as the person of first contact for their patients, and on whom their patients depend for diagnosis, treatment, or referral for all of their medical concerns. Another identified problem is that of a maldistribution of existing physicians. Whether or not sufficient numbers of physicians exist or will exist in the near future in the United States, there is little question that there are too few physicians of a given specialty in some areas and too many in others. Sparsely populated rural areas and densely populated urban ghettos are not the only target populations of this maldistribution. Many larger towns and smaller cities are as bereft of family practitioners and other types of primary care physicians as these more widely publicized areas. An additional concern to many is the lack of total numbers of physicians of all types existent in our State.

Perhaps part of the problem in the development of the situation where too few “generalists” and a maldistribution of physicians exists rests in the character of the medical education received by the students over the past generation or so. I will not delve into this further, concerning medical education of the past, but will reflect on some thoughts of mine relative to some possible changes in the character of medical education of the future that might have some bearing on these two subjects above.

Third Medical School

The expense involved in starting a third medical school (a second state-supported medical school in Georgia) has been seen to be prohibitive over the last few years. It is felt that more actual numbers of physicians may be turned out with less total dollar outlay under this new system, than the same number of physicians would cost being produced in a new medical school. The proposal in essence is to teach those pre-clinical subjects given in medical school in other colleges and universities

around the State, and to teach those clinical subjects, traditionally given in the latter portions of the medical school education, in scattered smaller communities around the State.

The basic medical sciences of a pre-clinical nature usually fall into the categories of anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology. Several of the four-year colleges and universities around the State presently teach some or several of these subjects, both at an undergraduate and at a graduate level. It would take considerably less expense to upgrade existing departments of biology and chemistry sufficiently to be able to teach effectively these subjects to medical students than it would to create such departments *de novo* within a new medical school, whether or not this new medical school would be created in an existing university. Thus, it would seem possible to me to include such course work in Savannah, Valdosta, Albany, Carrollton, Atlanta, and Athens at the very minimum. Medical students would take these courses while enrolled through the Medical College of Georgia, but resided at the institutions located in the communities named above. It is obvious that additional faculty and perhaps additional physical facilities will have to be secured for the science departments in these units of the University System in order for them to fulfill adequately the obligations of teaching graduate work in these areas. Nevertheless, as pointed out above, the total number of students so taught would cost the State of Georgia considerably less than if they were consolidated into a new college.

Clinical Education

Following completion of these courses, the students would be placed in various clinical settings throughout the State for their clinical education. Appropriate locations with interested and qualified physicians, and adequate clinical facilities would be selected throughout the State. A small group of students, perhaps in some situations even only one or two, would be placed in each location for the clinical experiences to be obtained. These would be

varied, of course, offering some electives for the student: such as those who are interested primarily in community family practice, or primarily in pediatrics, or primarily in public health practice, or primarily in surgery, etc.

The physicians involved in this clinical portion of the students' education would be *bona fide* members of the faculty of the Medical College of Georgia. In every way they would be similar to their peers who presently reside in Augusta, except that they would live and practice and teach in their own home community. Salaries for the physician-educators would be paid for from State funds administered through the Medical College of Georgia. Many details would have to be worked out concerning such things as salaries for part-time teaching, fringe benefits, teacher retirement, etc., and although tedious, would seem to pose no particular barriers toward the evolution of the program as such.

The clinical facilities themselves that are chosen could be a series of clinics, either private or public; a group of physician's offices; a hospital complex with extended care facilities in addition; or any combination of these. Again, these clinical facilities and teaching personnel would be set up deliberately by the curriculum committee of the Medical College of Georgia according to well thought out and pre-arranged philosophies, objectives and goals for the students involved. Thus, the kind of clinical education a student might get in Columbus might vary considerably from that that he would get in Toccoa, and both of these might vary considerably from that that he might get in Atlanta. Local administrators undoubtedly would have to be stationed in various spots around the State to keep track of things, but again, the cost of this kind of education would be considerably less than that of building a new medical school with a built-in, owned-and-operated teaching hospital of its own.

Inherent Benefits

Aside from the obvious financial benefits resulting from this method of educating medical students, I feel strongly that additional benefits are inherent. This kind of education probably would persuade a larger percentage of medical students to enter family practice, or primary care, as the mode of medical practice they wish to follow. I also feel that by being exposed during their medical education to various communities, by learning to know the people and the facilities available in these communities, that more students will be attracted to come and practice in these communities. This, then, would seem to help correct all three problems mentioned earlier: that of increasing primary care physicians;

that of decreasing the maldistribution problem; and that of increasing the total numbers of physicians overall.

I realize, as stated above, that there are many "bugs" to be worked out of this concept in bringing it to final implementation. However, ideas always must precede plans, which in turn must precede actuality. Such additional concerns to be integrated in this kind of a plan would involve the education of physicians' assistants and other types of allied health personnel along with the budding young physicians, so that each would learn the background and abilities of the other during the educational process, and therefore would be able to function in a practice setting more as a true team. Adding the education of allied health groups to this increases the logistical problems.

Another kind of problem that will have to be dealt with is the problem of accreditation, should this proposal reach some form of fruition. Presently, medical schools have rather rigid accreditation standards to meet. There is no question but that accreditation would become more difficult, more exasperating, and more time-consuming should the teaching of students be taking place all over the State. It is a rather novel idea at that to think that a student could become a physician, graduating from the Medical College of Georgia, and never have set foot in the city of Augusta!

Implementation Considerations

Another consideration to be given in attempting to implement this program would be in figuring out where continuing education, both for physicians as well as for the allied health team members, would tie in. Perhaps it would make it even easier because of the "mini-medical schools" in communities all over the State.

Whether or not you buy this concept; whether or not any part of this survives; or whether a totally new scheme arises and is acclaimed as workable, the above three kinds of problems: lack of primary care physicians, maldistribution of physicians, and lack of total numbers of physicians, will have to be addressed and an attempt made to solve them. Medical education of the past has created or participated in the creation of these problems, and therefore could not be expected to help solve them unchanged. Medical schools are alert to the need for change and welcome suggestions and positive criticisms from all sections. Organized medicine has the responsibility for criticizing positively the education of the next generation of physicians, and the obligation to do so. If this article promotes nothing more than discussion regarding the subject, it will have achieved its main purpose.

33 Gilmer Street, S.E.

Primary Medical Care: Whose Responsibility?

ROBERT E. REYNOLDS, M.D., Dr. P.H.,* *Augusta*

OVER THE PAST SEVERAL YEARS our nation has come to realize the existence of several serious defects in the "health care system" which it has developed. It has become commonplace for economists, political scientists, politicians, and many within the health care system itself to decry these defects and lay blame at the feet of the medical profession. Attention to these defects glosses over the tremendous advances in the biological sciences and the care and prevention of disease that have occurred since the turn of the century. Added to these specific medical advances are several other major reasons for the improved health status and well being of our populace, namely the incredible strides made in the American standard of living, including public sanitation, control of infectious disease and epidemics, improved nutrition, better housing and basic education.

The overall results of these combined improvements, advancements and strides are seen in our population of unequaled affluence, education, and medical care. Yet all is not well with our health status and medical care system. Our nation stands well down the international list in infant mortality, life expectancy, and several other commonly used parameters of the health of a population. Moreover, availability and accessibility of quality health care services are far from homogeneous in our country; selected populations, particularly the poor, the rural, and minority groups experience great difficulty in finding, paying for, and benefitting from the fruits of our great health care system. Health care costs keep rising, and rising at rates significantly out of proportion with the consumer price index in the general inflationary spiral. Hospitalization costs represent the major portion of these heightened health care costs, but it should be noted that physician's fees have increased considerably more than the general consumer price index during the last three years.¹ Another of the defects of our health care system, and the focus of this article, is the increasing shortage of physicians who function as generalists or primary care physicians in contrast

with the increasing number and proportion of physicians entering specialty and subspecialty fields.² To lay the blame for all these defects at the feet of the medical profession is both wrong and inaccurate. It is analogous to blaming the generals for the commencement and outcome of wars.

Specialization Defect

Specialization is by no means a new development in medicine. By the latter half of the nineteenth century at least seven medical specialties could be identified.³ Nonetheless, a very small number of such practicing specialists existed. The remarkable technological achievements in medical science during the present century have simultaneously precipitated and been supported by specialization of function. The stimulus to medical specialization afforded by the second world war and the heyday of biomedical research in the 1950's and 1960's (coupled with other factors such as differential fee schedules favoring specialists over generalists, the lack of a strong medico-political organization supporting generalists, and the absence of generalists on the faculty of medical schools) combined to undermine and deprecate the function, status, and reward systems of the generalist in American medicine. Today the adverse and unfortunate results of these trends are apparent. Among the loudest outcries from our citizenry are questions like "where can we find a family doctor?" "Who is to be responsible for continuity and the overall picture of our individual health needs?" "Who do we turn to *first*?" "Who puts it all together for us?" All these questions relate to the function of primary medical care and those professionals responsible for it.

This brings us to the question of definition of primary medical care. Medical care may be said to be primary when an individual patient identifies a specific physician and calls on him regularly for general physician services, including the initial assessment and medical advice during periods of illness, followed either by management of this illness by the primary physician or referral when appropriate to another physician. The primary physician emphasizes early diagnosis and treatment, appropriate

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patient referral for more specialized diagnostic and therapeutic techniques, disease prevention, health education and counseling. The elements of continuity over extended periods of time, awareness of the family constellation and the role of each individual patient within his family, and responsibility for coordinating and supervising most, if not all, health care services for his patient are important ingredients in the functioning of the primary care physician. Many of the problems brought to the primary care physician are vague, too early to be diagnosed with certainty and intimately related to psychological and behavioral problems. Therefore, they are not amenable to most of the precise and well defined diagnostic and therapeutic measures available to the specialist. Basic clinical skills augmented by mature judgement, educated pragmatism, broad clinical perspective and well developed communication skills are essential to the primary care physician.

The specialist by definition deals with a circumscribed area of knowledge and skills. This characteristic makes it difficult for the specialist, if indeed he limits his practice to his specialty, to acquire the information and skills necessary to perform the role of the generalist at the same time. Of course many individual specialists, particularly in internal medicine and pediatrics, simultaneously perform the functions of a generalist and a specialist. Unfortunately, the training programs which have produced these specialists usually do not prepare them for the complex role of a primary care physician. By his own skill, adaptability, perseverance, and insights, the specialist oftentimes becomes a very competent primary care physician as well as a specialist. However, the majority of such specialists would prefer to limit their practice to the specialty field in which they were trained and to transfer responsibility for the problems of primary medical care to someone else.

Primary Medical Care

Today primary medical care constitutes 60 to 75 per cent of all medical care delivered by physicians. Yet in 1968, 79 per cent of the physicians in the United States designated themselves as specialists and only 21 per cent designated themselves as general practitioners.⁴ These figures support the contention that many specialists combine the roles of generalist and specialist. This is particularly true of the fields of general surgery, general internal medicine, general pediatrics. Analysis of individual physician practices from these three fields also support this contention. Virtually none of these specialists have experienced formal training in the area of

primary medical care as it is understood today. Either by choice or by lack of sufficient number of patients in their specialty areas these physicians are performing dual roles.

Who provided primary medical care services in the past? Before the second world war the vast majority of medical school graduates entered general practice, the prevalent form of primary medical care then in existence. This followed the traditional pattern of a hundred years or more. The majority of these physicians received some hospital based training in pediatrics, internal medicine, general surgery, obstetrics and gynecology. In their individual practices they often chose to emphasize one area of medicine over others, but the general practitioner continued to play the role of a primary care physician. His four years of medical school and varying lengths of postgraduate training equipped him reasonably well to handle these functions. The tremendous advances in biomedical research and medical science had not yet made this a difficult role to play. After the second world war the developments in biomedical research and specialization began to threaten the role of the general practitioner and the number of physicians entering this field began to diminish. Subsequently we have witnessed a rapid decline in the number and proportion of general practitioners in practice.⁵ With the average age of our general practitioner group being somewhat over 50 years and many of the younger men leaving general practice to begin a residency in another field, a predictable crisis in the delivery of primary medical care will occur within the next decade or so.

Replace G.P.'s

Who is to replace this vital, productive, and extremely valuable group of general practitioners? Who will perform the functions of primary care in the future? With the possible exception of pediatrics there seems to be no discernable trend in the specialty fields to train their young physicians to carry out primary care functions in addition to specialty functions.⁶ To the contrary, the trend seems to be toward further subspecialization within these areas of specialization. Those young physicians entering internal medicine, pediatrics, and surgery who intend to practice a combination of primary care and specialty care find it difficult or impossible to receive a combination of training in these fields which will appropriately prepare them for a dual role.

Many specialists and academicians foster the opinion that primary medical care in the future will be delivered by groups of internists and pediatricians aided by obstetricians and paramedical personnel. This may be so. However, these groups are not now

being trained to perform or to understand the intricacies of primary medical care. Indeed, if they become heavily involved in primary medical care are we wasting their time in training them to be specialists in other fields? Will they not be engaged in primary medical care by default and necessity rather than by choice and training? It is doubtful that groups of these specialists and their attendant personnel will be willing to settle in towns containing two to five thousand people 50 to 75 miles from the nearest city. It may be feasible to form such groups and to practice medicine in densely populated urban areas, but this does not answer the needs of small towns and rural areas.

Another answer to the question, "who shall perform primary medical services in the future?" is supplied by allied health workers and some politicians who suggest that physicians' assistants be given this role. They would point to several developing countries and to our own military establishment to demonstrate that properly trained and supervised physicians' assistants can be a vital resource in dealing with the problems and patient load of primary medical care. Unquestionably this is a pragmatic approach to the question of quantity versus quality of medical care services. It is quite possible that our country could experience during the next decade such a crisis in primary medical care that physicians' assistants in large numbers would be suggested as the answer to the need for providing primary medical care. Perhaps under the supervision and guidance of groups of internists, pediatricians and obstetricians the physicians' assistant could perform the bulk of primary medical care. The quality and acceptability of these services on a large scale have yet to be demonstrated in this country.

American Board of Family Practice

An alternative approach to the problem of responsibility for primary medical care has been developed by the American Academy of Family Physicians. This group arose out of and replaced the American Academy of General Practice. It has undertaken to define a medical specialty called family practice and has differentiated it from general practice.⁷ Working with the American Medical Association it has established the American Board of Family Practice and has developed the details and guidelines for a three year residency program in family practice leading to eligibility to take the examination prescribed by the American Board of Family Practice.⁸ This Board is the first board recognized by the AMA to demand periodical recertification of its diplomates.

Since its inception in 1968 the American Board

of Family Practice has witnessed the development and approval of nearly 100 residency programs in family practice. Approximately half are situated in medical school-teaching hospital settings and the other half are in community hospital settings. The growth curve of the number of programs and the number of applicants to these programs is geometrical and astonishing. In several medical school teaching hospitals the family practice residency program threatens to become their largest residency program. The new humanism of the current generation of medical students and their revitalized concern for patients and their patients' problems rather than diseases and their technicalities seem to underlie this growth pattern. At the Medical University of South Carolina seven of the 12 first year residents in family practice are members of AOA, and this is not an uncommon occurrence in other family practice programs around the country.

The family physician as defined by the American Board of Family Practice serves as the physician of first contact and provides an accessible means of entry into the health care system.⁹ He evaluates his patients' total health needs, provides personal health care within the range of his competency, and refers patients when indicated to other specialists or community resources. He accepts responsibility for his patients' total health care including the use of consultants. He serves as coordinator of all his patients' health care services. In terms of traditional disciplines, the family practitioner is trained most heavily in general internal medicine, general psychiatry, general pediatrics, and normal obstetrics. No operative surgery is taught or to be performed by family physicians. Office gynecology, minor surgery and psychosomatic medicine are also considered legitimate portions of family practice. It is further felt that family practitioners should be taught to practice in small groups rather than in solo practice. They are taught to appropriately utilize the services of paramedical personnel, including physicians' assistants. The training of family practitioners stresses continuity of patient care and ambulatory medicine, but the resident also experiences rotations on the hospital services of internal medicine, pediatrics, surgery, obstetrics and gynecology, and psychiatry.

New Generalist

All in all, the new medical generalist is the family practitioner. If the success of this specialty follows the pattern set over the last three years, we will see the emergence of a strong, vital, professional group who will fill the void of primary medical care in this country, and thus may save us from a major revolution in health care.

A major quantity of resources must be devoted to this new specialty to maximize its potential and success. Already the federal government has recognized the necessity for the existence and success of this new specialty and has begun to funnel dollars into these programs. The medical students of today are clamoring for the humanistic and patient oriented medical specialty that family practice provides. Family practice has been accepted by the AMA and supported by the other specialty groups. It appears highly likely that family practice as a specialty will prosper and will play an extremely important role in the medical care system of the future. It may, in fact, become one of the largest and most vital of the specialty groups.

In summary, the shortage of primary medical care services is now recognized as a critical problem in our national health system. The rapid decline in the number of general practitioners and disappearance of general practice residencies have left a void in primary care being partially filled today by specialists in internal medicine, pediatrics and general surgery. Our pluralistic approach to medicine dictates that many of these specialists will

continue to function dually as primary and specialty care physicians. The development of family practice as a new medical specialty and differentiated from general practice holds the promise of specifically training young physicians to function successfully as primary care physicians. This is a development deserving of our attention and support.

Medical College of Georgia

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

February 20, 1972

AMA—Directed the Treasurer and Executive Director to present to the March meeting of Council a plan for financing an appropriate campaign for AMA offices for J. Frank Walker and J. Rhodes Haverty.

County Society Officers' Conference—Directed that J. Watts Lipscomb be sent a letter of appreciation for the excellent meeting planned by Dr. Lipscomb.

Podiatry—Considered a ruling by Attorney General Bolton that Podiatry fits the definition of the practice of medicine and directed that MAG's legal counsel present to the March meeting of Council a plan for legal challenge and its estimated costs.

License Renewal—Reviewed the recent action of the Licensing Board Secretary's Office, notifying physicians of non-renewals with penalties, and directed that the March Council agenda include a discussion of the possibility of MAG's including license renewal fees in central dues billing.

Nutrition Seminars—Voted to co-sponsor with AMA the Council on Foods and Nutrition Seminars at eight Georgia colleges.

Delegates' Handbook—Approved the compilation of a handbook of information for the MAG House of Delegates and directed that cost estimates be presented to the March meeting of Council.

Family Planning—Endorsed a resolution from the Georgia Council for Volunteer Family Planning regarding family planning for males.

Legislation—Authorized the Legislative Committee to proceed with whatever steps necessary to seek MAG's desired outcome on reorganization, while maintaining the integrity of the State Board of Health.

Foundation—Authorized foundation development of grant applications for a statewide emergency coordination system and a Family Medical Centers plan.

Next Meeting—10:00 a.m., March 11, 1972, Holiday Inn, Callaway Gardens.

Continuing Education and Community Hospitals

C. DANIEL CABANISS, M.D.,* *Columbus*

THE FIRST STUMBLING STEPS of peer review are forcing organized medicine to take a hard look at our system of education beyond formal training periods. As we look objectively at our work and our colleagues, educational needs become apparent. In realizing the need the first step is taken toward remedy.

At first glance physicians would seem to be the major recipients of continuing education. Rightly so, but all members of the health care team must participate. Active programs to enhance the educational experience of nurses and other paramedical personnel must be an integral part of continuing education programs. Such programs have the added benefit of increasing understanding of the various roles and contributions among members of the health care team.

Where to Teach?

Since the majority of physicians practice in community hospitals, it follows that educational efforts concentrated in these institutions will be most economical and reach the largest audience. Traveling to university hospitals for education, although pleasant and often rewarding, cannot fill the majority of needs. As presently constituted, many university based courses "miss the mark" of educational needs of community based physicians.

Locally based teaching in familiar surroundings with familiar faculty finds high acceptance and participation.

What to Teach?

Curriculum for continuing education is now receiving overdue investigation and much remains to be learned.

Obviously, if one writes down what he knows about a subject we can tell what he does not know, so the medical record should be a starting point. On a one-to-one basis as consultant to a primary physician this works well. Unfortunately, routine medical records vary so greatly in quality, large scale review for educational problems is fruitless.

Universal adoption of problem-oriented records may eventually answer the problem of making an "educational deficiency syndrome" diagnosis. Efforts to speed the spread of this excellent tool must be pushed.

Computerized programs such as PAS and MAP may help to pinpoint areas of deficiency but are not yet widely accepted and utilized.

As mentioned above, consultants and primary contact physicians may, through close interaction, discover gaps in each other's knowledge. This, however, is difficult to come by in other than anecdotal form.

Self-assessment tests may give some information and these agencies must be encouraged to give trends of educational deficiencies (anonymously of course) to those responsible for community hospital continuing education.

"Felt and expressed" educational needs have been shown to vary from "real" needs. However, this avenue must remain open. Programs based on such needs at least open the door to continuing education and set the stage for a more careful and critical approach to patient problems.

How to Teach?

As the content of community hospital education must respond to the needs of practicing physicians, so must the method.

First, the educational exercise must be regular. The interval is unimportant but it must be scheduled regularly in advance and never casually cancelled, giving busy physicians an opportunity to schedule.

Secondly, it should be brief. Two regularly scheduled one-hour sessions will be better attended than one two-hour session.

Third, it should be at a time and place most convenient for the physicians participating. In my hospital it's morning for internists, noon for surgeons and late afternoon for ob-gyn, etc.

Often a session tied to a simple luncheon enables this free hour to be utilized.

Fourth, it should be related to patient problems or patient care procedures. The grand rounds format with presentation of a problem or problems of a patient followed by a guided general discussion or

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HOSPITALS / Cabaniss

discussion by one especially qualified physician remains a rewarding educational experience. This must be carefully prepared and not left to chance. In such a program "relevance" is built in where such may be missing in the abstract lecture approach.

Occasionally the sessions may be the vehicle to introduce new patient care procedures or look critically at old ones.

Who Does the Teaching?

For continuing programs full or at least part time hospital educators are needed. It must be emphasized that their role is organizational and directive. They *do not* do all the teaching. Rather, for success, full participation of the attending physicians is needed.

The continuing education spin-off from house staff programs is great, as in teaching others the teacher receives most rewards.

Who Supports the Program?

At present, the major costs are borne by the community hospital and ultimately by patients. The benefits of continuing education to patient care are so obvious that this is a perfectly legitimate expenditure. If continuing education programs are coupled with efficient utilization reviews shortened hospital stay may more than pay the bill.

Lastly, community hospital programs are strengthened by medical school affiliation. Distinctly not a one way street, the interface between community and university strengthens both.

710 Center Street 31902

CAMP FOR DIABETIC CHILDREN TO OPEN

Georgia Diabetes Association will operate a camp for diabetic children for a two-week period July 2 through July 15, at the Baptist Assembly facilities near Roswell. This was announced by Dr. Ralph A. Murphy, chairman of the Camp Committee, and is a first for the Georgia Diabetes Association.

In the Atlanta area alone, there are more than 100 boys and girls of camping age (9-15). Other chapters and units of Georgia will find many other children who will be interested in attending.

The medical staff will be furnished by Grady and Emory Hospitals under the direction of John K. Davidson, M.D.

The cost per camper will be \$100.00 for the two weeks. Instructions in living with diabetes will be in-

cluded in the routine, which will include all sports and an enrichment program of creative crafts.

Diabetes Association of Atlanta has operated a day camp for the past three years at Zaban Park. This was in anticipation of the development of plans for a residence camp.

Each year in the past, approximately 30 children from Georgia have attended the Tennessee Camp for Diabetic Children at Double-G-Ranch, Soddy, Tenn. One hundred can be accommodated at the camp and T.C.D.C. gave neighborly priority to Georgia children.

All surrounding states have their own camps and Georgia is very proud to make the announcement that it is also planning for its diabetic children.

GEORGIA MEDICAL CARE FOUNDATION, INC.

I agree to continue membership and to support the Bylaws, Articles and philosophy of the Georgia Medical Care Foundation, Inc., for the fiscal year, June, 1972 to June, 1973.

NAME (Please Print) _____

ADDRESS _____

DATE _____

SIGNATURE _____

Mail to MAG Headquarters Office, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

Physician Assistants and Medical Practice

HARRISON L. ROGERS, M.D., *Atlanta*

DURING THE PAST FEW YEARS leaders in medical education as well as in other health-related fields watched the development of localities within our state and nation where it was felt that a shortage of health care existed. Some of these leaders felt that a true shortage existed, others felt that simply a poor distribution of health personnel existed, and still others felt that there developed simply an exuberant demand for more and better services. Whatever their reasons, all agreed that in many areas demand far outstripped supply.

With this realization, efforts were initiated to alleviate the problem. The most attractive solution was an immediate and wholesale increase in the number of graduates from our medical schools. Though the problems associated with this solution seemed insurmountable, great strides have been made and whereas we had 30,000 physicians graduated in 1960, this year, 1972, we will graduate 39,000 new physicians. The obstacles—first, of the shortage of suitable faculty in sufficient numbers and secondly, of the required large expenditures of money—were satisfied to a degree.

In an attempt to satisfy the initial need, i.e., more health care, more doctors were being trained and going into practice. Immediately apparent was the need for larger and larger numbers of support personnel. Consequently, during this same period, schools of nursing were encouraged to produce more graduates and new developments in nursing education were encouraged to produce more graduates in shorter periods of time.

New Personnel Category

When it became apparent that these increased supplies would still not meet the demands, other avenues were explored. The success of the many programs utilizing personnel other than the Doctor and the Nurse, such as the service "Corpsman," encouraged plans for the development of an entirely new category of personnel—the Physician's Assistant. With the passage in this state in 1972 of enabling legislation, the Physician's Assistant has been created in Georgia.

This individual in Georgia will not be individually licensed or certified, but will be a graduate of a Physician's Assistant program of a college or university which is approved by the State Board of Medical Examiners. The physician wishing to employ such a P.A. will submit an application to the State Board of Medical Examiners, including a de-

scription of the job to be performed by the P.A., together with a description of the moral and educational background of the proposed P.A. If the Board agrees, it will approve the application and the P.A. may be employed. However, if the P.A. leaves this physician, his next employer must reapply for approval.

The P.A. must work under the direct supervision of the physician, but not necessarily in his physical presence. The P.A. may make hospital rounds, house calls or may serve as an ambulance attendant. The P.A. must also work in the principal offices of the physician, who may employ a maximum of two such P.A.'s. The MAG, feeling that this was a new and untried form of health care, advised that the use of P.A.'s be restricted to those physicians in private practice initially. This was not made part of the final bill, however the legislation does stipulate that only those physicians engaged in primary patient care may utilize P.A.'s.

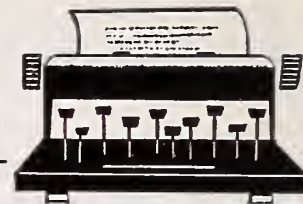
1972 Graduates

Thus it will be possible this year for the physicians of Georgia to employ the graduates of the P.A. schools of Emory, Georgia and Georgia State, as well as those of other approved schools. The use of the P.A. trained in any one of the many categories including (1) General Assistants; (2) Surgical Assistants; (3) Orthopedic Assistants; (4) Pediatric Assistants, etc., will begin as soon as the individuals are available and as each position is approved.

As with any new program it will be absolutely necessary that the physicians of Georgia give their closest supervision to the individuals so employed. Problems that arise must be carefully monitored and their solution discussed with the Board of Medical Examiners as well as with the appropriate committee of MAG (the Education Committee). If changes in the law are required either to broaden or restrict the scope of the P.A., then we will see to it that such legislation is introduced.

With the enactment of this law, the State Board of Medical Examiners is given the great responsibility of carefully monitoring the use of the P.A. in Georgia. This Board is composed of a fine group of men who will need our active support in beginning this new program. We are depending on them to provide the regulations to safeguard the people of our state and we must be ready to support and advise them in any way possible.

1293 Peachtree St., N.E.



The Accreditation Process as an Educational Tool

THE JOINT COMMISSION on Accreditation of Hospitals was formed in 1951 by the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association and the Canadian Hospital Association. The Joint Commission has carried on the work of the American College of Surgeons, begun over a half-century ago, attempting to identify quality of service in hospitals and other health care facilities, and to establish standards for the assessment of care.

The certificate of accreditation has meant that the institution has voluntarily submitted to outside, impartial appraisal and demonstrated to the examiners its ability to deliver quality care, as measured by adherence to certain professionally determined standards.

Now, as the delivery of care has grown increasingly complex, the Joint Commission is attempting to raise the standards from the level of "minimum essential" to the level of "optimal achievable" and "assure their suitability to the modern state of the art."

The Joint Commission sees its role changing from that of inspector, to that of evaluator and teacher; it seeks to help the institution identify both strong points and shortcomings, and to provide guidelines for correcting the deficiencies. It sees the accreditation process itself as an educational venture. It requires that the medical staff of the facility, having overall responsibility for the quality of medical care rendered, shall perform a continuing analysis, review and evaluation of the clinical practice of its members. In addition to the traditional tissue review and analysis of hospital deaths, the medical staff is now charged with reviewing the utilization of the facilities and resources of the hospital, concerning itself with the cost, as well as the quality, of health care. The staff must provide the appropriate peer group method to accomplish this. To be effective, such a program must involve each staff member; each member so involved will be reviewer, evaluator and teacher, and pupil; and the criteria developed for evaluation of care must be compared with the criteria developed by other hospitals in other areas of the country.

Such an exercise in self-evaluation, properly applied, cannot fail to be an exercise in self-education.

Summing up: "KNOW THYSELF."

Luther G. Fortson, M.D.

Phase II Effects on Physicians

ON DECEMBER 30, 1971, the Price Commission issued its regulations on providers of health services. Pursuant to this act, MAG Headquarters office has received many calls regarding application of these regulations. A summary of this information and the steps that should be taken towards compliance, follows.

The Price Commission has placed a 2.5 per cent ceiling on fee increases for physicians and all other non-institutional providers of health services, including medical laboratories, blood banks, dentists, podiatrists, physiotherapists, chiropractors and registered, practical and trained nurses. Essentially, this ruling will hold physicians' fees in effect as they were on November 14, 1971.

Any increases, up to the maximum of 2.5 per cent, must be justified on the basis of allowable cost increases. These increases must not increase the profit margin (the difference between gross income and net income).

The more puzzling of the regulations have been those referring to the posting of fees. A list of fees must be available for public inspection, and a sign is required to be posted, stating where the list of fees is located. Physicians can best meet these requirements by marking their regular charges on a copy of AMA's *Current Procedural Terminology*, available for \$2.00 from the AMA Circulation and Records Department. This booklet contains the approved five-digit coding and nomenclature for all procedures and can be kept in the receptionist's desk. A small sign (5" × 8") can be posted on the receptionist's window or placed elsewhere in the waiting room, and should read as follows:

"Our fees, in accordance with the Federal Price Commission regulations, are available on request from the receptionist."

Fees are not to be increased beyond the November 14 base until the sign is posted and the fee list is made available for public inspection, and increases are then limited to the 2.5 per cent figure.

A multi-level mechanism for price increases in hospital and nursing home charges has also been established and can best be summarized by saying that they are allowed up to 6 per cent cost-related increases. These institutional providers of health care are generally tied into the same restrictions faced by physicians. Costs in effect November 14, 1971, are their base prices and increases in profit margins are prohibited.

Any price or fee increases beyond the 2.5 per cent for physicians and other non-institutional providers, and beyond 6 per cent for institutional providers, fall under what is called the "provisions for exception by ruling."

Under these provisions, the physician or institution must request an exception from the price or fee provisions, to the Chairman of the Price Commission, by way of the District Director of Internal Revenue. The provider must justify the request for exception on the basis of serious hardship or gross inequity, and must convince the Commission Chairman that the request is not simply to get around the Economic Stabilization Act.

Wages and salaries of physician personnel are also restricted, and maximum increases for them are set at 5.5 per cent for the same period, exclusive of reasonable fringe benefits such as health insurance. Rents of commercial property, which includes most physicians' offices, are exempt from rent controls, but increases in costs of supplies are subject to the general 2.5 per cent price control.

Please take care to comply now with the fee list and sign-posting provisions of the regulations. Anyone found willfully violating the price stabilization regulations is subject to a fine up to \$5,000 for each violation and a court injunction to restrain further infractions.

Arthur lost



A single-dose, non-staining anthelmintic

his pinworms...



with just one non-staining dose of Antiminth (pyrantel pamoate) Oral Suspension.

Highly effective. Active against pinworm...and roundworm.

Non-staining. Doesn't stain teeth or oral mucosa on ingestion.

Doesn't stain stools, clothing or linen.

Simple dosage. Single-dose regimen: 1 cc. per 10 lbs. of body weight (1 tsp. per 50 lbs.).

Well-tolerated. Based on pre-introductory studies.

Pleasant-tasting. Easy-to-take, caramel-flavored oral suspension.

Economical. One prescription for the entire family.

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. Usage in Pregnancy: Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia.

Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lbs. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

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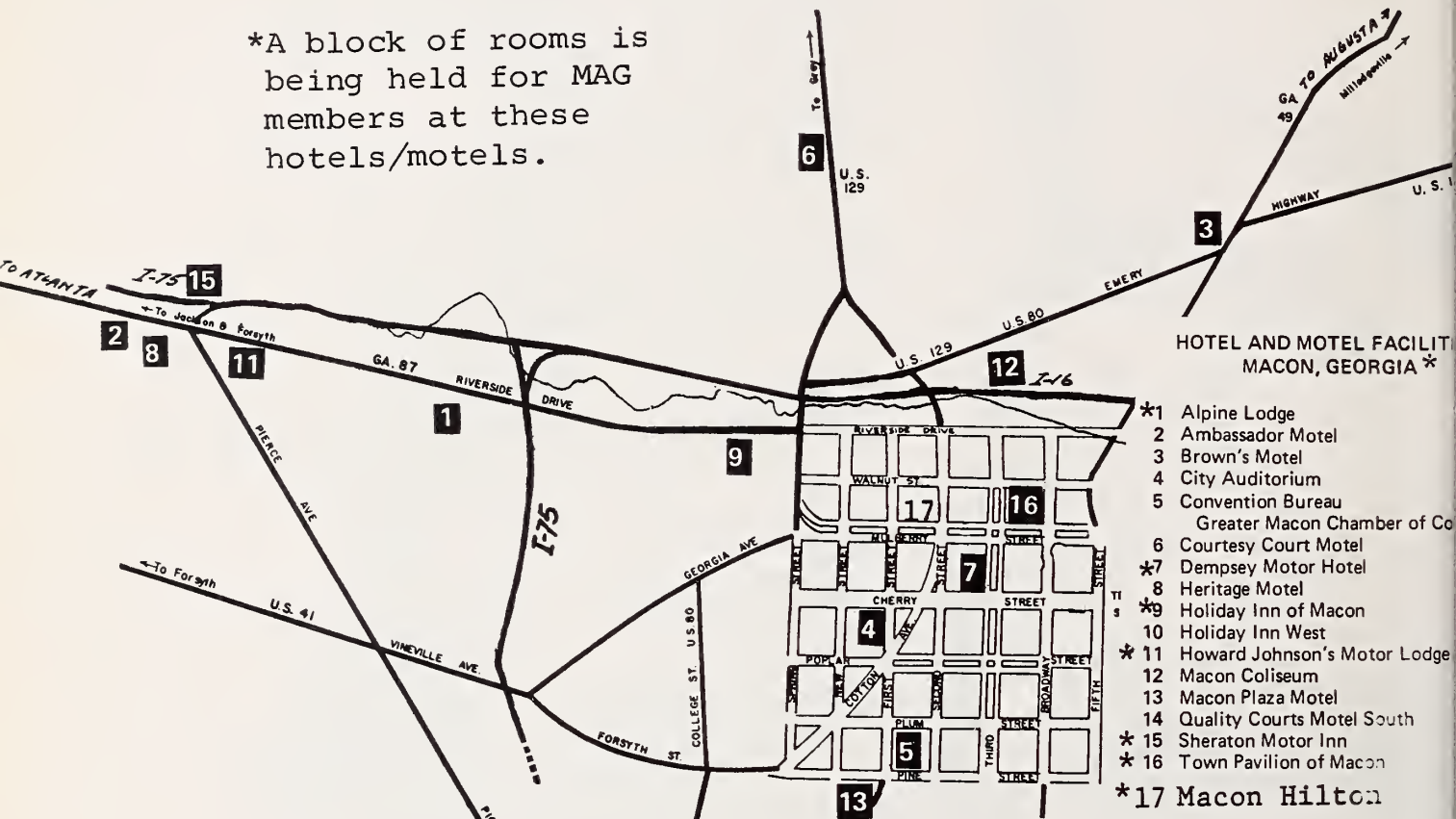
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1972 Annual Session

LOCATION OF HOTELS AND MOTELS IN MACON

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THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 11, 1972

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 12, 1972

- 9:00 a.m.—First General Session
First Session, House of Delegates
Featured Speaker: "Government Controlled Medical Care"
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Health Care Delivery Systems—Past, Present and Future"

6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 13, 1972

- 9:00 a.m.—Reference Committee Meetings
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"Venereal Disease," "Sex in Schools" and "Dynamics of Violence"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 14, 1972

- 7:00 a.m.—Prayer Breakfast
- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia

Annual Session

May 11-14, 1972—Macon, Georgia

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Howard Johnson's Motor Lodge 2566 Riverside Dr., Macon, Ga. 31202	Single—\$13.00-16.00 Double—\$18.00-21.00	\$3.00 \$3.00
Macon Hilton Hotel P.O. Box 144, Macon, Ga. 31202	Single—\$17.00 Double—\$23.00	\$6.00 \$6.00
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MAY 11-14, 1972

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TYPE OF ACCOMMODATIONS DESIRED FOR # OF PERSONS



A NEW FACE A-COMING

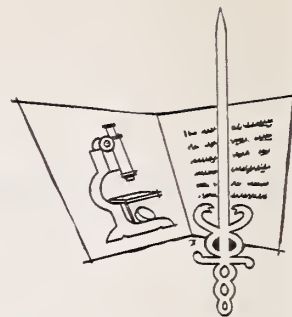
AT THE ANNUAL SESSION NEXT MONTH, it will be time for a changing of the guard, a passing of the torch, and off with the old and on with the new. In case this is confusing, I'm simply trying to imply that with the next issue of the *Journal*, a new face will grace this page and your incoming president will have the pleasure of imparting to you the benefits of his thinking here. It really doesn't seem that 12 months have gone by since I wrote my first article, but time does march on, and it will be necessary for me to fold my tent and become part of the background.

This has been a challenging year, but to say the least, it's been interesting! It was with the help of the hard working committees that really did the major part of the work, and with the help of a most efficient headquarters staff always at our beck and call, and also the help of those at home who manned the fort in taking care of my practice while I was away on MAG business. Without all these, the job would have been not only insurmountable, but entirely impossible. I will always remember the honor that was bestowed upon me in being elected to this office and this far surpasses any contribution I may have been able to make.

During the past year we did not accomplish everything that we had hoped. We lost the battle to retain the physician-controlled Board of Health, but no one can say that we failed to fight for what we felt was best for the people, who are the potential recipients of the health care we deliver. Even though we lost this battle, I do not feel that we have lost the war, for even now as we fall back to lick our wounds and regroup for those encounters that we know are before us, I believe each of you, even more so now, sees the necessity of a strong organization and a closer cooperation from all the membership in order to fight the ever present confrontations and the slowly creeping socialized take-over that has been so poignantly demonstrated.

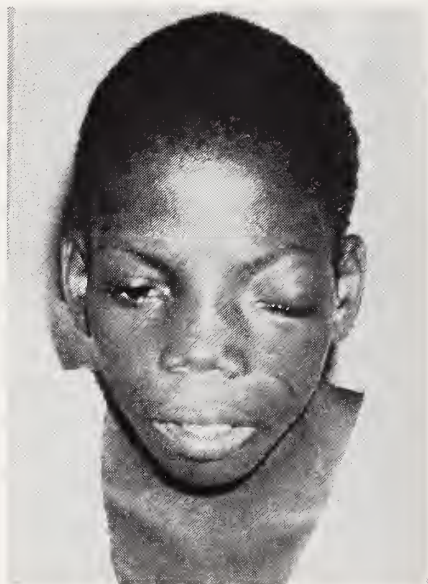
I shall be forever grateful to those of you who have taken your time to read the comments that I have made in the last 12 months, and a double portion of this feeling of gratitude goes to those of you who have told me that you liked them.

In 1927 (gosh, that's 45 years ago), while in pre-med at Emory University, there was an itinerant poet who had charge of chapel services one day and read many of his creative thoughts in poetry. I liked one of his poems so well that I purchased it for the sum of 25 cents, and with apologies to Riley Scott, I would like to pass it on to you because it is apropos with the changing of the face that you will see on this page next month. The title of the poem was "That Same Old Face."



CANCER EDUCATION FOR LAYMEN IN SOME OF THE AFRICAN COUNTRIES

ASA G. YANCEY, M.D., F.A.C.S., *Atlanta*



Male child, Burkitt's Sarcoma, left orbit, Korle Bu Hospital, Accra, Ghana.

IN AUGUST, 1971, the hospitals in the African countries of Liberia, Ghana, Kenya, Tanzania and Ethiopia were visited as an activity of the National Medical Association Post-Convention Seminar. Among many striking medical conditions seen, four cases of Burkitt's Tumor were observed in a single children's ward of Korle Bu Hospital in Accra, Ghana (photograph shows Burkitt's Sarcoma of orbit and maxilla). These children were in various stages of impressive regression of the tumor upon receiving cyclophosphamide therapy. Three patients with hepatoma were noted in one male ward in the Kenyatta National Hospital of Nairobi, Kenya; one of these had had a successful right hepatic lobectomy performed by a brilliant surgeon of Kenya.

When asked about their program of public education for the early detection of cancer, it was obvious that a vigorous program in Africa, such as the American Cancer Society perpetuates all over the United States of America, would fill a real and basic need. Any new nation has to determine its priorities. Other health needs such as developing medical schools, rural clinic construction, treatment of the severely ill and other basic needs must, at this time, take precedence over the expenditure of funds for the general education of the public relative to the early signs of cancer.

Though the work of the American Cancer Society has been tremendous, and as much as we have yet to actively instill in the minds of many Americans concerning the early symptoms of cancer, if one looks at Africa and much of the rest of the world, the task that yet lies ahead is a mammoth one indeed. International health organizations—working with and through national governments—may render an even greater service for world health, through cancer education.

35 Butler St., S.E. 30303



ECHOCARDIOGRAPHY

ISRAEL BELENKIE, M.D.,* *Atlanta*

THE FIRST ATTEMPT to employ diagnostic ultrasound in cardiology was in 1950. Although its usefulness in mitral valve disease was well described by the early 1960's, it has gained popularity slowly and it is only now that it is beginning to be used at many centers.

Principle

When a beam of ultrasonic wave is directed at structures of different densities, some of the waves are reflected at the interfaces between these structures. These echos are received, converted into electrical energy and displayed on an oscilloscope. An electrocardiogram is displayed simultaneously for timing purposes. Polaroid photographs are usually obtained from the oscilloscope so that permanent records are made from which appropriate measurements can be done.

Technique

With the patient in the supine position, the transducer is applied to the chest with a water soluble gel. Different cardiac structures are located and identified by their characteristic motion. The procedure usually takes from five to 20 minutes for mitral valve echograms but may take up to one hour for ventricular volume measurements. There is neither risk nor discomfort associated with the technique.

Uses

The motion of the anterior leaflet of the mitral valve is distinctly abnormal in all cases of mitral stenosis so that a normal mitral echogram rules out this condition. When present, the severity of the stenosis can be predicted with a high degree of confidence. Echocardiography is also a very accurate non-invasive method of assessing surgical results following mitral commissurotomy. There are several conditions in which the mitral valve motion may simulate that in mitral stenosis; however there is usually other echocardiographic and clinical information available to prevent a false positive diagnosis.

Tricuspid stenosis, which almost always occurs concomitantly with mitral stenosis, may be difficult to detect clinically but is usually easily identified echocardiographically. The Austin-Flint rumble associated with aortic regurgitation may be more easily proved by this technique.

In mitral regurgitation, mitral valve motion is often abnormal. There is an overlap with normals, however, and the practical value of echocardiography here is limited. The type of mitral regurgitation that is associated with the systolic click-late systolic murmur syndrome has a characteristic pattern of mitral valve motion that is probably diagnostic.

Many, and perhaps most, patients with idiopathic hypertrophic subaortic stenosis (obstructive cardiomyopathy) can be confidently diagnosed using echocardi-

* Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

ography and the effect of treatment can be observed by serial changes in the echocardiogram. Most of the remaining patients with this condition can be identified by doing an echocardiogram during pharmacological maneuvers.

Echocardiography is probably the most reliable and sensitive non-invasive technique currently available for the detection of pericardial fluid and, as such, may be extremely useful in assessing patients with enlarged cardiac silhouettes when an effusion is suspected. Pericardiocentesis, if required, can then be performed with confidence in the diagnosis.

The assessment of ventricular function using echocardiography is currently being studied widely. Initial results in the measurements of ventricular volume, stroke volume, cardiac output and ejection fraction correlate remarkably well with cardiac catheterization data. Although these results are encouraging, it is still premature to apply this technique extensively for this purpose.

Other uses of echocardiography that are currently being investigated include the differentiation between acute and chronic aortic regurgitation, assessment of prosthetic valve function, detection of left atrial myxoma and aortic dilatation or aneurysm. It is a diagnostic aid in congenital heart disease, in pulmonary embolism, in determination of left atrial size and in the occasional identification of a myocardial aneurysm.

Summary

Echocardiography is a non-invasive technique that can be employed safely, reasonably rapidly and without discomfort to the patient, both as a diagnostic aid and in assessing the severity of a variety of cardiovascular conditions. Although probably not practical for use by a lone physician at present, it would be appropriate for use in almost any size hospital or group practice.

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PATIENT'S RELEASE DOES NOT RELEASE PHYSICIAN

JOHN L. MOORE, JR., *Atlanta**

JACK D. KNIGHT, JR. was seriously and permanently injured in an automobile accident on February 25, 1967. He was treated by Dr. Lowery, a neurosurgeon, from the date of the accident until April 1, at which time he was transferred to his hometown hospital. After again examining the boy on April 12, Dr. Lowery had no further contact with the Knights until their suit against him was commenced.

On June 30, 1967, Jack's parents executed a release in favor of Harold and Jack Boling, the driver and owner of the automobile involved. The release also ran in favor of State Farm Mutual Automobile Insurance Company, the Bolings' insurance carrier, and "all other persons." The Knights received a payment of \$10,500, the maximum extent of the Bolings' liability and medical payment coverage with State Farm.

The release signed by the Knights was a pre-printed form containing blank spaces in which were inserted the typewritten names of the Bolings and of State Farm, the date of the accident, and a brief description of the accident. Dr. Lowery was not named in the release. The pertinent language from the release read as follows:

"... the undersigned hereby releases and forever discharges Jack Boling, Harold Boling and State Farm Mutual Automobile Insurance Company, their heirs, executors, administrators, agents and assigns, and all other persons, firms or corporations liable or who might be claimed to be liable, none of whom admit any liability but all expressly deny any liability, from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever and particularly on account of all injuries, known and unknown, both to person and property, which have resulted or may in the future develop from an accident which occurred on or about the 24th day of February, 1967, at or near Fitzgerald, Ben Hill County, Georgia, in which accident Jack D. Knight, Jr., minor son of the undersigned, sustained severe, permanent and permanently disabling injuries."

The Knights then proceeded to file suit against Dr. Lowery for professional negligence, alleging that he had failed to diagnose and remove a subdural hematoma which developed during his course of treatment, thereby causing further injury to their son's brain.

Dr. Lowery's attorneys set up as a defense to the action against him the execution and delivery of the release described above, asserting that the release barred the action against Dr. Lowery. The trial judge granted the physician's motion for summary judgment made on that basis, and the Knights appealed to the Court of Appeals of Georgia.

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia. The case described is *Knight v. Lowrey*, Case Nos. 26754 and 26756, Supreme Court of Georgia, December 2, 1971.

The Court of Appeals affirmed the trial court, holding, "purely as a matter of contract law," that the release was unambiguous and that Dr. Lowery was entitled to rely upon the release.

Supreme Court Decision

The Supreme Court of Georgia took jurisdiction of the case and reversed the decision of the Court of Appeals by action of a divided Court.

The Supreme Court alluded to the fact that Georgia had previously been among the majority of States in the United States saying that a general release of all persons included the physician treating the person injured in the accident. However, the Supreme Court noted that it had in the past held that release of one of the negligent parties in the accident also released any other negligent party in the accident. The Court went on to say that this holding did not cover the situation presently before it in Jack Knight's case. The Court carefully said that the physician's negligence, if any, was a different wrong to Jack. The Court also pointed out that a growing minority of States was re-examining the whole question.

The Supreme Court also held that the Knights could introduce non-written evidence of their intention in executing the release. Presumably they would say that they had not intended to release the physician but only the negligent driver, the owner, and their insurer.

Comment

This December, 1971, decision apparently changes the law in Georgia on this particular point. What should a physician do? If he has treated the victim of an accident, should he ask his patient or the patient's parents whether they plan to settle their claim against the negligent driver? Should he also say that he would like his name written in the release? Would this imply that he thinks he might be guilty of malpractice? Should the physician contact the negligent driver and his insurer to be sure that they write his name in the release?

Obviously, the treating physician will do none of these things, and it appears that the reported decision is one more stone in the wall being built around doctors at the present time.

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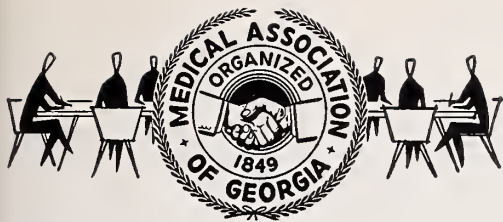
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THE ASSOCIATION

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Dickens, Winburn J. Active—Barrow—GP	802 East Ave. Winder, Georgia 30680
Heath, Ricardo Active—Southwest Ga.— GP	Edison Clinic Edison, Georgia 31746
Hilsman, A. H., III Active—Fulton—P	811 Juniper St., N.E. Atlanta, Georgia 30308
Hoffman, Kathryn A. Active—Meriwether-Harris —PM	The Foundation Warm Springs, Georgia 31830
Jurkiewicz, Maurice J. Active—Fulton—Pl	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Mullis, Kenneth L. Active—Laurens—GP	309 Bellevue Ave. Dublin, Georgia 31021
Tidwell, Oliver K. Active—Troup—R	City-County Hospital LaGrange, Georgia 30240
West, John T. Active—Troup—Su	Vernon Rd. LaGrange, Georgia 30240

PERSONALS

Third District

Joseph C. Serrato of Columbus was initiated into the Mexican Academy of Culture at a special meeting of the academy, called in his honor, in February.

Fifth District

James L. Clements, Jr., has been promoted to professor of radiology in the Emory University School of Medicine.

Lamar B. Peacock was installed as president of the American College of Allergists at their annual meeting March 5-9, 1972, in Dallas, Texas.

Seventh District

William B. Dillard, Jr., of Cartersville, has been re-elected to active membership in the American Academy of Family Physicians.

DEATHS

Glenn Jackson Bridges

Glenn Jackson Bridges died at his home in Atlanta February 26 after a prolonged illness. He was 66.

A graduate of the Atlanta College of Pharmacy and the Medical College of Georgia, Dr. Bridges was a member of Phi Rho Sigma, Theta Kappa Nu and Laconte fraternities. He was also a member of the First Presbyterian Church, Druid Hills Golf Club, Fulton County Medical Society, Medical Association of Georgia and the Atlanta Urological Society.

A former Public Health Officer in Millen and Savannah, he had practiced medicine in East Atlanta and Atlanta for 30 years.

Dr. Bridges is survived by his widow, the former Margaret Eugenia Raymond, of Augusta; a daughter, Lucy Jane Bridges Altizer; three sons, Glenn Jackson Bridges, Jr., M.D., Chandler Raymond Bridges and Andrew Phillip Bridges, all of Atlanta; sisters, Mrs. Ruby Durham of Savannah, Mrs. Mable Benson of Athens and Mrs. Mildred Maughon of Atlanta; brothers, Ralph Bridges of Santa Cruz, California, John Bridges of Houston, Texas and Roy Bridges of Gainesville; and a grandson, Douglas Leo Altizer, Jr., of Atlanta.

Richard Heath

Richard Heath died February 25 at Palmyra Hospital in Albany, following an illness of five days.

A member of the staff of Calhoun Memorial Hospital and staff doctor for the Calhoun Nursing Home, Dr. Heath was a member of the Southwest Georgia Medical Association, a Mason, a Shriner and a member of the Eastern Star and Scottish Rite.

He was a member of the Methodist Church, the Edison Lions Club and the Calhoun County Country Club.

Dr. Heath is survived by his widow, Mrs. Carolina Farias Heath; sons, Edward Heath of Miami, Florida and Richard Heath, Jr., of Ecuador; daughters, Mrs. Donald Niese of Houston, Texas and Mrs. Lawrence Rowe, also of Texas; and seven grandchildren.

James F. Olley

James F. Olley, chief pathologist and director of the clinical laboratory at Crawford W. Long Memorial Hospital, died February 13 in a private hospital following a heart attack. He was 50.

Born in Northumberland, Pennsylvania, Dr. Olley graduated from Harvard University Medical School and was a teaching fellow at Jefferson Medical College and Bucknell University. Since coming to Atlanta more than 20 years ago, he has been an associate professor of pathology at Emory University.

He was a member of the American Board of Pathology, the Society of Clinical Pathologists, the College of American Pathologists and the Atlanta Clinical Society. He also was a member of Phi Beta Pi fraternity, the Masons and St. Anne's Episcopal Church.

Survivors include his widow, three daughters, two sons, a sister and a brother.

THE MONTH IN WASHINGTON

The Price Commission restricted increases in a physician's fees to 2.5 per cent a year when justified by increases in his costs, but granted the right of appeal to the Internal Revenue Service for a further increase for those physicians with greater increases in their costs of conducting a practice.

The official regulations went into effect December 29, a day before they were published in the *Federal Register*. The commission earlier had announced guidelines on which the regulations were based.

The regulations require that a physician maintain a schedule of fees and increases with a sign in his office that such a schedule is available for inspection. But he does not have to post them in his office.

After issuance of the regulations, AMA officials continued meetings with federal officials in efforts to effect modifications of provisions considered unfair to physicians. The meetings started before issuance of the guidelines.

One meeting was with Donald Rumsfeld, director of the President's Cost of Living Council, a few days before the regulations were issued. Dr. Max H. Parrott, chairman of the AMA Board of Trustees and head of its delegation, voiced strong exceptions to some of the price control provisions which would deny treatment equal to that given other providers of professional services.

The Price Commission has ruled that "a non-institutional provider of health care services may charge a price in excess of the base price only to reflect allowable costs in effect on November 14, 1971, and allowable cost increases incurred after November 14 reduced to reflect productivity gains, and only to the extent that such increased price shall not result in an increase in such provider's profit margin as a percentage of revenues, before income tax, over that prevailing in the base period, providing, however, that the provider's aggregate price increases shall not exceed 2.5 per cent per year."

The AMA has pointed out that the Price Commission's 2.5 per cent limitation on the increase of physicians' fees was discriminatory inasmuch as other providers of services could reflect actual increases in cost by a "pass through" of such costs, a procedure denied physicians under the proposed regulations.

The AMA also pointed out that while the Price Commission urged increased physician productivity, the proposed regulations might well decrease productivity.

The physician cannot generally work longer hours than he is presently working, the AMA position paper said. He can expand his office space, purchase new testing and diagnostic aids, and employ more staff.

But held to a 2.5 per cent fee increase—in the face of higher costs—he is apt to do none of these things.

The AMA paper also took exception to the proposed requirement for the posting, or having available, a fee schedule. It is simply not practical for a physician to arrive at a schedule of prices for each and every one of the numerous services he renders, the AMA said, pointing out that it was its understanding that the Committee on Health Services Industry, an advisory body to the Price Commission, recognized this fact and had recommended that posting be limited to institutional providers.

The AMA also pointed out that the proposed guidelines do not provide for a procedure under which physicians whose fees are below the norms in their communities may adjust their fees. Physicians usually maintain their fees for several years and then increase them by 10 or 20 per cent to counter inflation, rather than impose annual increments of 25 or 50 cents, the AMA said, insisting that the proposed regulations should contain reasonable criteria for handling unusual situations such as these.

At the suggestion of Mr. Rumsfeld, the AMA has taken its case directly to C. Jackson Grayson, Jr., chairman of the Price Commission, and additional meetings have been scheduled. The full text of the AMA's position paper on this subject has been forwarded to all state medical societies.

Cancer Legislation

President Nixon signed into law a sharply stepped-up program to combat cancer.

In signing the legislation before several hundred leaders in the field at a White House ceremony, Nixon expressed "hope that in the years ahead we will look back on this as the most significant action taken during this administration."

The new law, which authorizes expenditure of \$1.6 billion in the next three years, gives the National Cancer Institute partial autonomy and puts it to a large extent under the White House although it remains in the National Institutes of Health.

Its chief will be appointed by the President, its activities monitored for the President by a special three-man advisory board, and its budget submitted directly to the White House.

Nixon predicted the new organizational setup "will enable us to mobilize far more effectively both our human and our financial resources in the fight against this dread disease."

The revamped organizational structure is a compromise between proposals to establish a separate, wholly independent cancer authority under the White House and to leave NCI in NIH but with a greatly expanded program.

The main thrusts of the new cancer research program are being developed by a committee of 280 non-government scientific consultants and will be completed by March.

The prime goal will be to find drugs that are effective against "slow-growing" tumors—malignancies that affect such organs as the lung, breast, colon and bladder and account for 85 per cent of the 650,000 new cancer cases a year.

The Cancer Institute plans to organize "task forces" to launch a coordinated attack against specific forms of cancer, including lung, bladder, prostate and large bowel. This approach is credited with achieving substantial success in treating childhood leukemia.

The President also signed into law a \$673.6 million bill financing continuance of the federal government's programs to aid medical, dental, nursing and allied health schools. It was about \$150 million more than the administration requested, but \$200 million below the figure approved by the Senate. Medical and dental schools were allotted \$460.4 million, compared with

the administration's request for \$366 million. Nurses got \$145 million.

Commission of Medical Practice

An American Medical Association spokesman said a solution to the medical malpractice problem must be found "which will provide equitable protection for the patient and the physician and which will not contribute unreasonably to the cost of medical care."

Dr. Arthur J. Mannix, Jr., of New Rochelle, New York, outlined the AMA's position at a hearing of the government's special commission of medical practice. Dr. C. A. Hoffman, AMA president-elect and chairman of the AMA Professional Liability Committee, is a member of the Commission.

"The physician should be permitted to treat his patient in an atmosphere of mutual trust and confidence, without continual threat of malpractice charges," Doctor Mannix said.

"Some means must be found which will provide equitable protection for the patient and the physician and which will not contribute unreasonably to the cost of medical care.

"New systems, perhaps one based on scheduled benefits, or a system of limited and well-defined "no fault" coverage may be the answer. We recognize that many questions will have to be considered when any major change is contemplated. Will the patient population, for example, be willing to yield its rights to adversary litigation as they know it now? In the interests of reduced medical care costs, would they accept, as another example, scheduled compensation perhaps limiting recovery to economic losses? In any event, any viable solution will have to be based on acceptance by public.

"We believe that additional experimentation with a variety of means may lead to a more satisfactory resolution of the problems facing us. The physicians of this country would welcome measures alleviating the many problems present today in the practice of medicine as it relates to malpractice liability. . . . The American Medical Association offers to this Commission its assistance as solutions are sought to this complex problem."

Dr. Mannix outlined the AMA's activities in the field which culminated in the negotiation of a contract with CNA as insurance carrier and Marsh and McLennan as national administrator for the establishment of sponsored malpractice insurance in states which do not have them.

Barbiturates Restrictions Discussed

The American Medical Association opposed further government restrictions on barbiturates.

Dr. Henry Brill, a member of the AMA's Committee on Alcohol and Drug Dependence, pointed out to the Senate Juvenile Delinquency Subcommittee that barbiturates and other sedative drugs already are subject to tight controls under a federal law—penalties for illicit sale, restrictions on refilling of prescriptions, and mandatory registration by physicians who prescribe or dispense them.

"To add to the present restrictions on barbiturates so as to reduce medical overuse would be a disservice to patients who need them," Dr. Brill said. "Not only would it be more difficult to prescribe and administer such drugs in the treatment of numerous illnesses and disease, it would inevitably raise the costs of hospital

care in direct proportion to the additional record-keeping and reporting that would be required of these institutions, where so great a proportion of sedatives are used in therapy.

"On the other hand, we vigorously support efforts to control street traffic and diversion of drugs. We also subscribe to and support the intensification of education and persuasive techniques to help assure the proper utilization of these drugs in medicine. We would urge medical schools to incorporate comprehensive material on drug abuse and drug dependence in their curriculums, stressing the importance of an accurate assessment of the abuse and dependence potential of patients when psychoactive drugs are medically indicated. Continuing education efforts should stem largely from drug utilization committees in hospitals where both the medical staff and house officers, together with nursing personnel, can benefit from an ongoing evaluation of prescribing practices."

Influenza Outbreaks

The federal government reported at the end of 1971 that outbreaks of influenza were hopscotching across the country in a fashion typical of the 1969 epidemic that struck an estimated 30 million Americans.

The National Center of Disease Control (NCDC), a part of the Department of Health, Education and Welfare with headquarters in Atlanta, Georgia, said some of the influenza has been identified as the Hong Kong variety and some as "influenza-like." School absenteeism ranging as high as 30 per cent was reported by communities hardest hit by the bug.

The influenza struck swiftly and spread rapidly. Practically no outbreaks were reported by state health departments in a telephone survey conducted by the NCDC on November 17-18. But another phone survey conducted December 21 revealed outbreaks in New England, the Middle Atlantic states, Midwest, South and the Far West. The Hong Kong influenza "has been documented in Connecticut, Kansas, Michigan, New Jersey and Utah," the NCDC said.

"Increased influenza-like disease has been reported from Colorado, Idaho, Indiana, Louisiana, Maine, Massachusetts, Montana, New Mexico, Oregon, South Dakota and Wyoming," the center said.

The disease was reported to have caused mild symptoms in its victims.

The World Health Organization said that influenza epidemics, much of it caused by the Hong Kong virus, have broken out in both Eastern and Western Europe.

President Nixon said his Administration will expand its programs to improve the nation's emergency medical services and to combat diseases of the heart, blood vessels and lungs.

In the long version of his two State of the Union messages to Congress, the President said the "staggering" U.S. death toll from accidents—more than 115,000 last year—"could be greatly reduced by upgrading our emergency medical services." He said it could be done without new scientific breakthroughs if present knowledge were applied more effectively.

"To help in this effort," he said, "I am directing the Department of Health, Education and Welfare to develop new ways of organizing emergency medical services and of providing care to accident victims. By improving communication, transportation, and the training

of emergency personnel, we can save many thousands of lives which would otherwise be lost to accidents and sudden illnesses.

Significant Accomplishments

“One of the significant joint accomplishments of the Congress and this administration has been a vigorous new program to protect against job-related accidents and illnesses. Our occupational health and safety program will be further strengthened in the year ahead—as will our ongoing efforts to promote air traffic safety, boating safety, and safety on the highways.

“In the last three years, the motor vehicle death rate has fallen by 13 per cent, but we still lose some 50,000 lives on our highways each year—more than we have lost in combat in the entire Vietnam war.

“Fully one-half of these deaths were directly linked to alcohol. This appalling reality is a blight on our entire nation—and only the active concern of the entire nation can remove it. The federal government will continue to help all it can, through its efforts to promote highway safety and automobile safety, and through stronger programs to help the problem drinker.”

Presidential Promise

Nixon promised increased attention to the diseases of the heart, blood vessels and lungs “which presently account for more than half of all the deaths” in the nation.

“I will shortly assign a panel of distinguished experts to help us determine why heart disease is so prevalent and so menacing and what we can do about it,” he said. “I will also recommend an expanded budget for the National Heart and Lung Institute.”

He also called upon Congress to act upon his proposals for national health insurance, health maintenance organizations and elimination of the monthly fee now charged under part B of medicare.

The President said he later will propose legislation “to reform and rationalize” the delivery of social services, including health services.

“We need a new approach to the delivery of social services—one which is built around people and not around programs,” he said. “We need an approach which treats a person as a whole and which treats the family as a unit. We need to break through rigid categorical walls, to open up narrow bureaucratic compartments, to consolidate and coordinate related programs in a comprehensive approach to related problems.”

Estimated Spending

In his fiscal 1973 budget, Nixon estimated federal spending on HEW health programs at \$18.1 billion, an increase of \$1.1 billion over the current fiscal year which ends next June 30. A breakdown under broad categories shows:

HEALTH			
(Fiscal years, millions of dollars)			
	1971	1972	1973
	(actual)	(est.)	(est.)
Development of Health Resources			
Budget authority	2,293	2,965	2,851
Outlays	2,201	2,446	2,787

Financing Medical Services			
Budget authority	12,657	15,633	20,115
Outlays	11,946	14,214	14,733
Prevention and Control			
Budget authority	360	571	737
Outlays	319	382	619
Offsetting Receipts			
Budget authority	-3	-18	-22
Outlays	-3	-18	-22
Totals			
Budget authority	15,307	19,151	23,681
Outlays	14,463	17,024	18,117

The fiscal 1973 budget calls for a \$49 million increase—to \$435 million—for delivery of health services programs—health maintenance organizations, regional medical programs and health planning agencies.

Expenditures for medicare and medicaid were estimated to increase by \$492 million. The federal share of medicaid was estimated at \$3.4 billion or 55 per cent of the total cost. Outlays for medicare were estimated at \$10.4 billion in fiscal 1973.

Other spending estimates included:

Food and Drug Administration—\$179.5 million, an increase of \$69.7 million.

National Institutes of Health (mostly biomedical research)—\$1.57 billion, an increase of \$139 million. Of this, \$430 million goes to the Cancer Institute.

Caution from Council

The President's Council of Economic Advisers, in its annual report to Congress, cautioned that money alone does not hold the solution to the nation's health problems. New criteria for evaluating medical care should be developed, the council said.

The council said that the nation's medical care expenditures totaled \$75 billion—\$358 per person—in fiscal year 1971, an annual growth rate of 4.3 per cent per capita since 1966.

“Although improvement in the health of the population was clearly the ultimate goal of these expenditures,” the council said, “it is also true that the relation between good health and medical expenditures is less than direct. First, our medical dollars may not always be used effectively. Ideally, the preferences of consumers and capabilities of suppliers freely interact in the market to determine the price and amount of the commodity consumed; and this interaction leads to the use of resources that best contributes to the material well-being of people. In the case of medical care, however, distortions in this process occur because, on the demand side, consumers are not always able to judge the service, and, on the supply side, competition is often limited by restrictions on entry into medical practice and hospital services. Although these restrictions may have been intended to protect consumers, as a side effect they may also impede the efficient utilization of resources. In addition, the dominant position of nonprofit organizations in the market providing hospital services raises other questions about whether incentives to minimize costs are as great in medicine as in other parts of the economy.

Health Factors

“Yet even great improvements in the market for medical care would not solve all health problems. Another important problem arises because good health is related to many factors in addition to medical care. Some of these factors are subject to an individual's con-

trol: diet, exercise, smoking, and consumption of alcohol. Other conditions, such as the amount of pollution in the air and water, depend rather on the actions of society as a whole. In addition, there are more elusive influences, like the tension generated by attitudes toward work and other circumstances of modern life. The importance of life styles and environment to health has become much more apparent in recent years.

"To start to answer the general question of how we can best 'produce' health, we must find a way of measuring changes in the level of health. What must be measured is the actual output-health—not simply such inputs as amounts of medicine consumed, days spent in hospitals, or the hours in consultation with doctors. While no comprehensive measures of the national health have been developed, and each existing measure has its limitations, such indicators as mortality rates and disability days have been widely used to trace changes over time and to compare localities. The relationships observed between these measures of health and other variables have revealed a number of paradoxes. . . .

"Since medical care is likely to remain a major instrument for improving the nation's health, and since it is a focal point for public policy, there is a clear need for developing tests for the effectiveness of medical care. At present, we do not have the data required to make such tests, and thus we can evaluate only imperfectly the efficacy of alternative medical care policies."

Medical Teams

The federal government announced the first assignments of federal doctors and other health workers to provide direct patient care in rural and big city areas with critical health manpower shortages.

Teams with a total of 68 medical workers, including doctors, dentists and nurses, will be assigned to 18 communities in 13 states to work with such patient groups as Indians, migrant workers, welfare families and minorities.

The first team, a husband-wife, doctor-nurse duo, was assigned to a 14-bed hospital in rural Jackman, Me., in September. The second team went to work in Immokalee, Fla., in November. March 1 is the target date for assigning the other 16 teams, a spokesman for the National Health Service Corps said.

The Corps was created Dec. 31, 1970, when President Nixon signed the Emergency Health Personnel Act, which calls for government health workers to provide direct health services to residents of city slums and remote rural areas designated as having critical health manpower shortages.

The lag in starting the project had sparked charges by some Congressional Democrats that the Administration was delaying it. The Administration had replied that recruitment was difficult.

Dr. David A. Kindig, recruitment chief for the Corps, admitted that the major incentive for doctors to join had been the military draft. All 28 doctors among the 68 initial medical workers were recruited from the Public Health Service (PHS) Commissioned Corps, and "many of them are still fulfilling their military obligations," he said.

The teams also include 10 dentists, 18 nurses and 12 other professionals, including pharmacists, dental hygienists, health educators and lab technicians, Kindig

said. Recruitment of some team members, like nurses, may be done at the local level, he said.

Control Transfer

The Nixon Administration said that it hopes to transfer eight U.S. Public Health Service (PHS) hospitals and 30 government clinics to local control by June 30, 1973.

Health, Education and Welfare Secretary Elliot L. Richardson said President Nixon's budget for the fiscal year beginning next July 1 "assumes that these facilities will be converted to community use by June 30, 1973." The budget is expected to go to Congress next Monday.

The hospitals, with a combined 2,484 beds, are in Baltimore; New Orleans; Staten Island, N.Y.; San Francisco; Seattle; Norfolk, Va.; Boston, and Galveston, Tex.

"We cannot yet predict what effect the current reviews of PHS hospitals and clinics will have on those now employed in those installations"; Richardson said in a statement. "No change in employment as a result of these reviews will occur this fiscal year (ending next June 30)."

Richardson's announcement said an administration decision has been made to eliminate 8,087 HEW jobs between now and next June as part of a government-side plan to reduce federal employment.

Drug Abuse Attacked

President Nixon signed an executive order establishing the Office of Drug Abuse Law Enforcement which will marshal a wide range of government resources "in a concentrated assault on the street level heroin pusher."

Miles J. Ambrose, who had been Customs Commissioner, was appointed to head the new office.

"I am convinced that the only effective way to fight this menace is by attacking it on many fronts—through a balanced, comprehensive strategy," Nixon said in a statement.

He said the Administration has worked for three years to eliminate dangerous drugs at their source, cutting off their international flow.

"Today our balanced comprehensive attack on drug abuse moves forward in yet another critical area as we institute a major new program to drive drug traffickers and drug pushers off the streets of America," he said.

Nixon praised Ambrose, 45, a lawyer and former New York enforcement official, as a man "who knows how to take care of this problem of law enforcement."

Implementation

Nixon said the office would work through nine regional offices and use special grand juries to gather information about drug traffickers. He said this intelligence will be pooled for use by federal, state and local law enforcement agencies.

The latest FBI uniform crime statistics available show that 451,000 persons were arrested in 1970 for narcotic drug law offenses, up 44 per cent from 1969 but accounting for just 4.8 per cent of arrests for all offenses in 1970.

In 1970, the FBI noted that 53 per cent of all persons arrested on drug-related charges were under 21 years of age.

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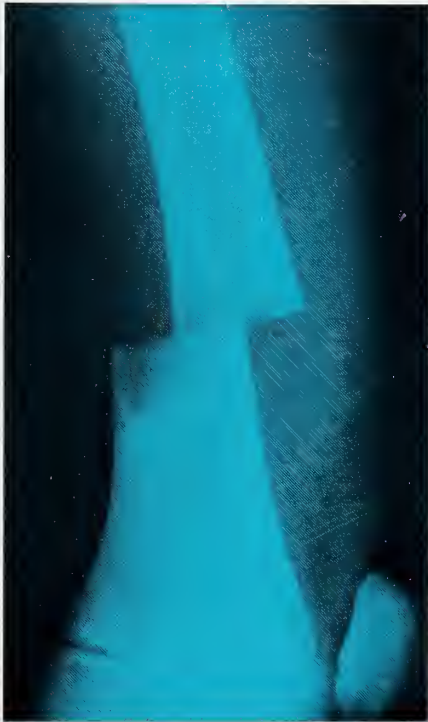
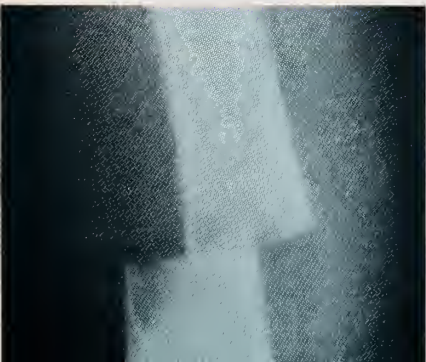
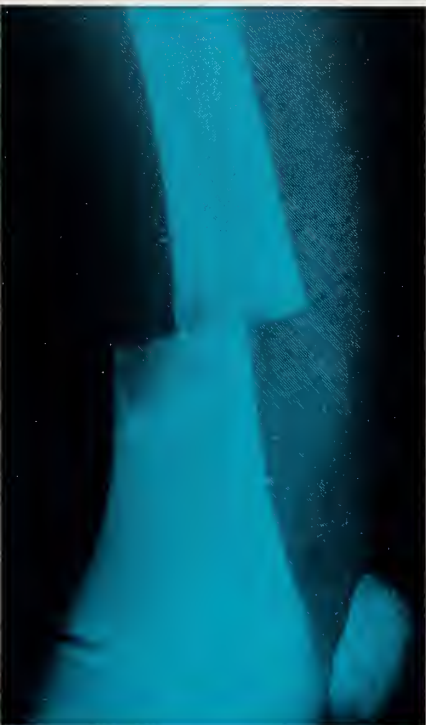
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**CYSTIC
BONE
LESIONS**
See Page 153





The negative power of undue anxiety
in congestive heart failure...

This man thinks he can no longer
take breathing for granted.

X-Ray Seminar Number 4

A Cystic Lesion in the Femur

WILLIAM WHITAKER, M.D., and GERALD DOMESCIK, M.D., Atlanta*

DR. WILLIAM WHITAKER: The patient for presentation is a 15-year-old male who had this radiograph following trauma to the right lower extremity. Dr. Domescik, what do you think of these films?

Dr. Gerald Domescik: There is an obvious fracture of the distal femur (Fig. 1). This is a pathological fracture. The fracture line extends through a cystic defect in the distal shaft of the femur. This is a very benign appearing lesion. It has a well-formed ring of sclerosis about the lesion, there is no evidence of extension or permeation of surrounding bone. There is no evidence of periosteal reaction. Radiographically, this most probably represents unicameral bone cyst. It is centrally located in the femoral shaft.

Other lesions which may produce a similar appearance, such as chondromyxoid fibroma of bone, occupy a position more eccentric in location. Non-ossifying fibroma of bone would have to be considered. It is also usually more eccentrically located. There appear to be bone chips within the lesion. Some observers use this as a very reliable sign of a bone cyst. This has been referred to as the "fallen fragment" sign. This indicates that the lesion is soft or fluid-filled, allowing the fragments of the margin to be displaced inward into the lesion.

Dr. Whitaker: This is a follow-up film of the femur after a period of four months (Fig. 2).

Dr. Domescik: The fracture is well healed, but the cystic lesion is still present.

Dr. Whitaker: The cystic lesion persisted and three years after the fracture the lesion was curre-



FIGURE 1

Right femur demonstrating pathological fracture extending through cystic intramedullary lesion.

ted and bone chips were placed within the lesion. Would you discuss the histology of this lesion, Dr. Gravanis?

Dr. Michael Gravanis: The slide demonstrates evidence of production of new bone. There is osteoid which is becoming calcified. At the same time, there

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements, Jr. and H. S. Weens.



FIGURE 2

Follow-up radiograph after four months demonstrating healing of the fracture, but persistence of the cystic intramedullary bone lesion.

are some areas demonstrating "channels." When you see channels such as this, when the surgeon says that the lesion contained bloody fluid, you always think of aneurysmal bone cyst, rather than unicameral bone cyst. These channels are not vessels; muscle tissue or elastic tissue cannot be demonstrated in these channels. With the amount of reactive bone shown in the sections I believe that aneurysmal bone cyst is much more likely rather than unicameral bone cyst, which is a true cyst of bone. I would favor aneurysmal bone cyst.

Dr. H. S. Weens: What is the difference between unicameral bone cyst and aneurysmal bone cyst?

Dr. Gravanis: The true unicameral bone cyst is a thin-walled cyst with not too much reaction, unless there has been a fracture, with a thin wall of fibrous tissue within it. There are no giant cells or proliferation of fibrous tissue, which are in abundance in aneurysmal bone cysts. The aneurysmal bone cyst is made up of spaces containing liquid blood, however this is not considered to be a true cyst. It may be the

result of previous trauma. It is not uncommon for aneurysmal bone cyst to be superimposed on some other lesion. The pathologist is aware of this and looks for another lesion when there is histological evidence of aneurysmal bone cyst.

Dr. Wade Shuford: Since a cyst, by definition, is a structure containing air or fluid, are you justified in calling this a cyst on the basis of the radiographic appearance? A bone lesion filled with fibrous tissue or granulation tissue would produce the same appearance on the radiograph.

Dr. Domesick: The bone chip which appears to be "floating" in the cavity represents a fragment which was displaced by the trauma. This indicates that there is liquid within the structure allowing this fragment to be displaced inward. If this cavity were filled with solid material, the bone fragments would not be displaced within the lesion.

Dr. Weens: The older textbooks and statistics point to the most frequent location of unicameral bone cyst in the humerus, however I think more recent statistics indicates that the most common site for unicameral bone cyst is in the femur.

Dr. Gravanis: The same thing can be said for aneurysmal bone cyst. The old literature indicated that the most common site for aneurysmal bone cyst was in the vertebra, however, more recent statistics indicate that approximately one-fourth are in the vertebra and the remainder are found localized to the extremities.

Comment

Aneurysmal bone cysts show no distinct sex predilection and over 75 per cent occur before 20 years of age. The clinical symptoms are pain, restriction of motion and swelling. The usual site of location is the shaft of the long bones near the metaphysis but any bone may be involved. The epiphysis is spared.

Roentgenographically, a well circumscribed, eccentric located area of rarefaction associated with soft tissue extension is the characteristic appearance. Usually, the soft tissue mass will be bounded by a thin rim of expanded cortex. Trabeculation may or may not be seen.

A unicameral cyst also is predominant during the first two decades of life. Clinically, the patients are usually asymptomatic and the cyst comes to attention after a pathological fracture occurs. This lesion occurs in the diaphysis of the long bones and produces fusiform widening with thinning and erosion of the cortex. Trabeculation, like aneurysmal bone cyst, may or may not be seen. The epiphysis grows away from the cyst so that it usually lies near the center of the shaft. The demonstration of "Fallen Fragments" helps to substantiate the diagnosis.

The histopathology of aneurysmal bone cysts and simple cysts overlap and often differentiation is impossible.

Emory University 30322

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2. Dahlin, D. C.: *Bone Tumors*. Springfield, Ill., Charles C Thomas, Publisher, 1957. Pp. 242-243, 250-251.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

Saturday, March 11, 1972

Finance: Recommended to Council that \$150 be added to the budget of the Committee on Mental Health for travel, and \$100 be appropriated for a mailing to support the nomination of J. Rhodes Haverty for an AMA Council seat.

Reorganization: Voted to recommend to Council that Doctors Mitchell, Dowda, Eldridge, David Wells and Henry Scoggins be named to the Board of Human Resources Nominating Commission, with Eldridge as Chairman for MAG.

Miscellaneous: Mr. L. B. Storey has officially replaced Miss Thelma Franklin as Assistant Director, Business and Finance. Miss Franklin has been retained as a Consultant.

The two Georgia Blue Boards' Executive Committees would meet March 16.

Council would receive a report from the Committee

on Insurance and Economics with a request for a 17 per cent increase in Liability Insurance premiums, the smallest in many years.

The Bibb County Medical Society would be surveyed by AMA.

The Georgia Medical Care Foundation would develop District Foundations based on medical market areas.

State appropriations to the State Medical Education Board would provide for 42 scholarships in 1972.

The FLEX Exam would be given to Georgia Medical License applicants beginning 1972.

Studies should be given to the idea of holding Executive Committee Meetings in various parts of the State, with District Meetings.

Next Meeting: Sunday, April 16, MAG Headquarters, Atlanta.

HIGHLIGHTS OF MAG COUNCIL

Saturday, March 11, 1972

Finance: Voted \$1,500 to Committee on Legislation; \$100 for mailing for J. Rhodes Haverty for AMA Council on Medical Education; \$3.43 to Past President's Travel; \$48.70 to AMA Delegates' expense; \$150 to Committee on Mental Health; \$4,500 to Office Travel; and \$145 to print a Parliamentary Handbook for the MAG House of Delegates.

Board of Human Resources: Named Doctors Mitchell, Dowda, Eldridge, D. Wells and H. Scoggins to the Nominating Commission.

Podiatry: Authorized legal counsel assist Attorneys for Georgia's Blue Shield plans in appealing rulings that podiatrists practice medicine.

Insurance: Approved new liability rates effective June 1: Class I—\$212; Class II—\$341; Class III—\$797; Class IV—\$935; Class V—\$1,048 representing a 17 per cent increase, the smallest in recent years.

Council: Voted to retain its present name.

Constitution and Bylaws: Approved language for introduction to the House of Delegates making all Past Presidents Honorary Members of Council and AMA Alternate Delegates Ex-officio Members of Council without the right to vote.

Component County Societies: Voted approval of the new Hall County Medical Society Constitution and Bylaws.

Price Commission Suit: Voted instructions to AMA Delegates to support action that AMA assist the Florida Medical Association in its suit declaring price commission rulings on physician fees at 2.5 per cent to be discriminatory.

Composite Board of Medical Examiners: Voted that the MAG *Journal* print an annual reminder of license renewal dates.

Woman's Auxiliary: Learned that AMA Auxiliary President, Mrs. G. Prentiss Lee, will attend the MAG Annual Session in May.

Osteopathy: On learning that language for bylaws amendments allowing osteopaths to join MAG would be introduced in the May House of Delegates, voted that information on this subject be distributed to Delegates.

Next Meeting: 2:00 p.m., May 10, 1972, Macon-Hilton Hotel, Macon.

The Diagnosis of Cystic Fibrosis in the Practice of Allergy

DONALD C. McLEAN, M.D., *Atlanta**

THE DIAGNOSIS OF CYSTIC FIBROSIS and atopic disorders in childhood may be confused, as these two entities share common symptom complexes and physical findings. The two cases presented demonstrate some of the similarities. These similarities and other distinguishing features will be discussed.

Case No. 1

E. H. is a 10-year-old white male who was referred to the Lowance Clinic because of "allergy." Three years prior to this visit, his mother noted the onset of cough. This cough was episodic and was not associated with frank wheezing. Classic hayfever symptoms were manifest in the spring and fall of each year. Exposure to cats, feathers, wool and pollens caused sneezing. Sputum and nasal discharge were usually yellow in color, and stools were said to be normal. Eczema was never present. A sibling died of "intestinal obstruction" and the patient was known to have an elevated white blood count. There was a bilateral family history of allergy. Physical examination revealed a small white male (lower third percentile) with obvious clubbing of the fingers and toes. The sinuses did not transilluminate and rhonchi were heard in the chest. White blood count was 26,000, nasal smear showed 3+ eosinophiles, and the sweat chloride was 133 mEq/L. Chest and sinus films were performed (Illustrations I and II). Allergy skin testing was positive for pollens and house dust. Pulmonary function studies included a normal vital capacity and blood gases, as well as moderate airway obstruction.

Case No. 2

D. W., an 8-year-old white male, was referred to an allergist because of cough. The suspicion of cystic

fibrosis arose, and the patient was referred to the University of Virginia Hospital for further diagnosis and treatment. Recurrent coughing, wheezing and fever had been prominent since the age of six weeks. Pale, bulky stools had always been noted, and growth milestones were retarded. Physical examination revealed an increased AP chest diameter, rhonchi on auscultation of the chest and a protuberant abdomen. Nasal washings were purulent, and sweat chloride was 117 mEq/L. Pansinusitis and hyperinflation were noted on respective sinus and chest x-rays. Allergy skin testing corroborated a positive atopic history. Pulmonary function studies were characterized by airway obstruction, normal vital capacity and normal blood gases.

Nasal Mucosa and Allergy

Nasal eosinophilia is said to be indicative of atopic allergy. Nasal polyps are found in patients with both allergic diseases and cystic fibrosis. Chart review of patients attending the Grady Memorial Hospital Cystic Fibrosis Clinic was unrevealing in regard to nasal eosinophilia. Nasal polyps occurred in some 30 per cent of cystic fibrosis patients. Our experience would suggest that nasal polyps are rare in children with atopic allergy and that nasal eosinophilia is a relatively uncommon finding in patients with cystic fibrosis. However, Rourk and Spock¹ note that 50 per cent of a random group of 56 cystic fibrosis patients present nasal eosinophilia. They also note that atopic allergy is very common in the cystic fibrosis patient group (\pm 50 per cent) and agree that nasal polyps "did not correlate with skin tests or eosinophilia." Shwachman, et al.² found that nasal polyps occur in 6.7 per cent of the cystic fibrosis population and that the presence of nasal polyps dictates that the child "should be examined for evidence of cystic fibrosis."² Kulczycki³ and others found that atopic allergy occurs in 16.6 per cent of their cystic

* Assistant Clinical Professor of Pediatrics, Emory University School of Medicine.

Presented at Southeastern Allergy Association, Annual Meeting, Regency Hyatt House, Atlanta, October 3, 1970.

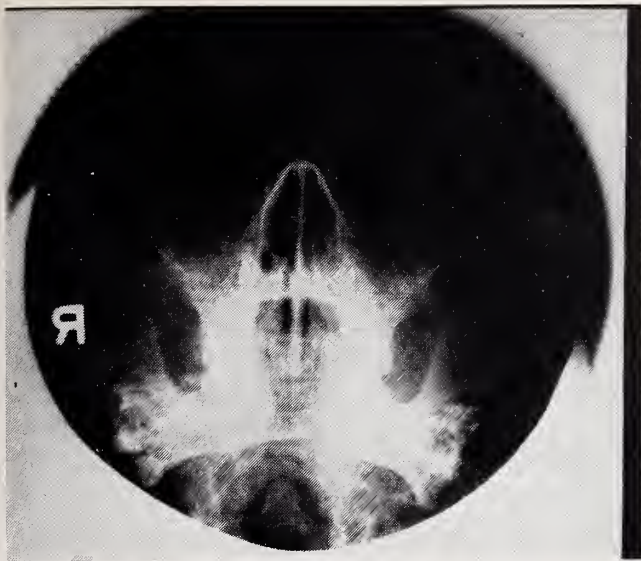


FIGURE 1

Sinus x-rays, Case 1.

fibrosis patients (a figure comparable to the general population), and Van Metre⁴ accepts the presence of nasal polyps as evidence of allergy in patients with cystic fibrosis. Thus, some confusion exists in this area.

Paranasal Sinuses

Most authors agree that involvement of the paranasal sinuses is very common in cystic fibrosis. Ninety-three per cent,² 92 per cent⁵ and 100 per cent⁶ are the per cents of cystic fibrosis children with sinus disease reported in these groups studied recently. Our experience is similar. An almost 100 per cent incidence of sinusitis has been noted both at the Grady and University of Virginia cystic fibrosis clinics. An obliterative process involves the sinuses of the cystic fibrosis patient and, by its very nature, may suggest the diagnosis of cystic fibrosis. This process is shown in Figure 1.

Pulmonary Function

In an excellent review of the subject, Zerkowicz, et al.⁶ state that: "Cystic fibrosis has been found to be associated with a pattern of airway obstruction, poor intrapulmonary gas mixing, increase in residual volume, loss of lung elasticity and changes in gas diffusion." They find that airway obstruction, as measured by the maximal mid-expiratory flow rate (MMEFR), is the most sensitive early measure of abnormal pulmonary function. This would again agree with our findings at the University of Virginia Pulmonary Laboratory. Airway obstruction was the most common early abnormality. Arterial blood gas determinations were frequently normal until late in the course of the disease (Table 2). Abnormalities in vital capacity (restriction), gas mixing and increasing airway obstruction are noted as the disease

TABLE 1
REVIEW OF 20 CASES OF CYSTIC FIBROSIS
UNIVERSITY OF VIRGINIA—1968

1. Moderate airway obstruction
2. Normal blood gases
3. Normal vital capacity
4. Above unrelated to x-ray findings

advances. Thus, the mildly affected cystic fibrosis patient may have pulmonary function studies similar to the childhood asthmatic. Reversibility of obstruction after inhalation of isoproterenol is only sometimes helpful as a differential diagnostic tool.

Chest

Radiologic examination of the chest may or may not be an aid in differentiating cystic fibrosis patients from normal or other chronically ill patients. A pattern of hyperinflation with associated physical findings of wheezing may make the cystic fibrosis patient indistinguishable from the asthmatic using these two criteria. A normal chest x-ray can co-exist with the diagnosis of cystic fibrosis or, conversely, advanced chronic changes may be easily demonstrated. As in most childhood pulmonary disease, the chest x-ray is a helpful adjunct to diagnosis, but must not be relied on to differentiate or identify a specific disease process (Fig. 2).

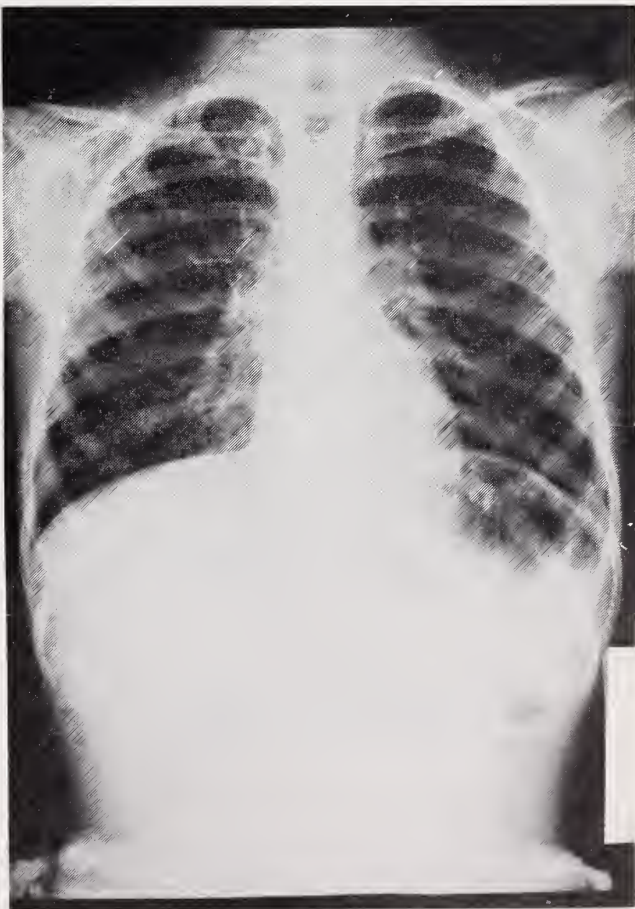


FIGURE 2

Chest x-ray, Case 2.

TABLE 2		
ATOPY	BOTH	CYSTIC FIBROSIS
	wheeze chest x-ray airway obstruction	polyps white blood count clubbing sweat test
	sinusitis	
←	nasal eosinophiles	→
←	+ skin tests	

TABLE 3 CASE SUMMARIES		
	Case No. 1	Case No. 2
Chief complaint	cough	cough
Reason for referral	allergy	allergy
Sputum	yellow	yellow
Stool	normal	abnormal
Growth	retarded	retarded
Family history	positive	negative
Physical examination	wheeze clubbing sinus disease	no wheeze clubbing sinus disease
Pulmonary function	obstruction	obstruction
White blood count	elevated	normal
Sweat chloride	133 mEq/L	117 mEq/L
Allergy	yes	yes
Nasal eosinophilia	yes	no

Other

The sweat chloride determination is the definitive diagnostic tool identifying the cystic fibrosis patient (greater than 60 mEq/L). We have noted two other, perhaps helpful, differentiating points. Clubbing of the fingers and toes is rare in childhood asthma, but more common in cystic fibrosis. Markedly elevated white blood counts may also point to the diagnosis of cystic fibrosis. We have seen a number of cystic fibrosis patients with WBC's greater than 20,000 without any striking evidence of active infec-

tion. This, again, is rate in uncomplicated, non-steroid treated atopic diseases.

Discussion

Table 3 summarizes what we believe are the identical and distinguishing features of these two groups. A careful history, including inquiry about growth patterns, stool composition, family history of intestinal obstruction and family history of pulmonary disease, should alert the examiner to the possibility of cystic fibrosis. However, in the setting of a selected atopic group, this may be a less obvious difference. Physical findings of nasal polyps, purulent nasal discharge, rectal prolapse, serious sinus disease and nail bed clubbing should also warn the observer that cystic fibrosis may exist. Of course, these two entities may co-exist and further confuse the picture (Cases 1 and 2). The mildly affected cystic fibrosis patient may have physical findings, chest x-rays and pulmonary function studies which are indistinguishable from the childhood asthmatic.

It behooves the allergist to be aware of the possibility of the diagnosis of cystic fibrosis. If this diagnosis is missed, future therapeutic, social and legal consequences may result. The definitive diagnosis rests with a sweat chloride determination of 60 mEq L or greater.

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58th Annual Clinical Conference

AMERICAN COLLEGE OF SURGEONS

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Two cases are reported and proper surgical management is outlined.

Mesenteric Vein Thrombosis Secondary to Polycythemia Vera

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POLYCYTHEMIA is defined as an abnormal increase in red blood cell mass. Two categories of the disease, primary polycythemia and secondary polycythemia, are usually recognized.

Primary polycythemia, often called polycythemia vera, is characterized by hyperplasia of all the cellular elements of the bone marrow, particularly red blood cells. It is often regarded as a malignant neoplastic disease analogous to leukemia, and eventually may terminate as a leukemia. It is a disease of middle age, seen infrequently in Negroes, and occurs mainly in the male sex. In contrast to secondary polycythemia, the arterial saturation is usually normal.¹

In a recent report from the Mayo Clinic, 19 patients with polycythemia vera had age and laboratory values ranging as follows: age, 43 to 83 years; Hemoglobin, 16.8 to 23.1; Hematocrit, 58 to 80; RBC, 5.1 to 9.4 million; WBC, 6,600 to 19,500; Platelet count, 112,000 to 692,000.³

Pathologic Physiology

The pathologic physiology of polycythemia vera includes the following abnormalities: increased total blood volume, increased blood viscosity, thrombocytosis, and slowed velocity of blood flow. These factors, acting in combination, result in two serious complications: intravascular thrombosis and bleeding tendency. Thrombosis is due to increased viscosity and thrombocytosis. Bleeding results from trauma to distended vessels and from the poor quality of clot associated with platelet and plasma factor deficiencies.¹

Secondary polycythemia includes a variety of conditions which are associated with decreased oxygen saturation of the blood. Tissue hypoxia in the kidneys results in release of the hormonal substance

erythropoietin which in turn stimulates erythropoiesis in the bone marrow. Thrombocytosis, however, is not usually present. Conditions associated with secondary polycythemia include right to left cardiac shunt, emphysema, high altitudes, and inherited hemoglobin anomalies. In addition, a form of secondary polycythemia occurs when various malignant tumors and cysts, particularly in the kidney, elaborate substances having erythropoietin-like activity.¹

Surgical manifestations of this disease include vascular thrombosis and hemorrhage. This disease is frequently unsuspected when patients are first seen by the surgeon. Because of the importance of recognizing the disease when present, since specific considerations are required in the proper handling of such patients, two recent cases of polycythemia vera complicated by mesenteric thrombosis are herein presented.

First Case

A 51-year-old white male was admitted to the Veterans Administration Hospital with abdominal pain of seven days' duration. The pain was sudden in onset, unrelenting, and gradually increasing in severity. He had been treated in a community hospital two years previously for dizziness, blurring of vision and nose bleeds, at which time a diagnosis of polycythemia vera had been established. Phlebotomies, repeated periodically, had been effective in relieving symptoms.

Examination upon admission showed a ruddy-complected middle aged male, somewhat dehydrated, in moderate discomfort. The abdomen was distended and generally tender with guarding. Bowel sounds were sparse. A peritoneal tap revealed bloody peritoneal fluid. Hemoglobin was 19 grams, hematocrit 62, WBC was 22,000. Serum amylase was normal. The platelet count was reported as "increased." Abdominal x-rays showed normal gas pat-

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POLYCYTHEMIA VERA / Edmondson

terms in the large bowel and one isolated loop of small bowel in the right lower quadrant.

A preoperative diagnosis of infarcted bowel was made and surgical abdominal exploration was carried out without delay. The liver was normal and the spleen was slightly enlarged. Approximately three feet of ileum was necrotic: it, along with its segment of mesentery, was markedly congested, swollen, and discolored. The large vein at the apex of the specimen was occluded by a fresh thrombus. The involved area was resected with end-to-end anastomoses.

The operative blood loss of 1,300 cc was replaced with fluids only. The hematocrit postoperatively remained about 40 per cent. On the seventh postoperative day the patient developed sudden onset of painful swelling in the right big toe. The uric acid was slightly elevated at 4.1 mgm per cent. This appeared to be gout and it responded favorably to cholechicine. The remainder of the postoperative period was uneventful and he was referred back to his family physician.

Second Case

A 64-year-old Caucasian male was admitted to the Veterans Administration Hospital with a 48-hour history of cramping, abdominal pain, distension, and vomiting. Past history revealed previous hospitalization for diabetes (which was controlled by diet), arthritis, and carotid sinus syncope. He had had no surgical operations. All previous admissions were characterized by hematocrit and hemoglobin determinations above 50 per cent and 18 grams respectively, but there was no prior recorded suspicion of polycythemia and no recorded erythrocyte or platelet counts.

Hemogram on admission revealed hematocrit 59 per cent and hemoglobin 19 grams. White blood count was 17,000 with 69 neutrophils, 6 bands, 18 lymphocytes, 1 eosinophil and "adequate" platelets.

X-ray of the abdomen revealed an occasional loop of distended small bowel on the right side.

Physical examination revealed a "ruddy complected" male with hypoactive bowel sounds in a tender and distended abdomen, a blood pressure of 150/90 and pulse of 104. He appeared acutely ill. A peritoneal tap showed blood-tinged intraperitoneal fluid.

He was surgically explored and found to have a localized venous infarction of the distal ileum. The involved bowel was markedly swollen from passive congestion, due to fresh clot of a large mesenteric vein draining the area. Approximately 8 inches of ileum was resected and the postoperative course was

uncomplicated. After complete workup, he was considered a case of polycythemia vera.

Discussion

Surgeons are frequently the first physicians to treat patients with polycythemia vera. Unfortunately there are case reports of patients being operated upon more than once, each time with complications, before polycythemia was finally diagnosed. The correct preoperative diagnosis, therefore, is critical.³

Approximately 35 per cent of all polycythemics have thrombotic or bleeding complications. Thromboses may occur in the heart, lungs, brain, abdominal viscera, and extremities. The spleen, which is usually enlarged as a feature of the disease, is subject to thrombosis and infarction. However, unless obviously infarcted, it should not be removed as the resulting thrombocytosis adds to the already present thrombotic tendency. Polycythemia should be ruled out in unexplained thrombophlebitis of the leg. Bleeding peptic ulcers, gastritis, or diverticuli are further complicated by an underlying polycythemia.

The preoperative care of the patient will be mainly tempered by the urgency of the situation. If time permits, a suggested regimen is removal of 1,000 cc blood per day until the hematocrit is 50 per cent. Instead, myelosuppressive treatment may be instituted, particularly when thrombocytosis is severe.³

During the operation ordinary blood losses are replaced with fluids other than blood. If blood replacement is required, fresh blood may be preferable. Meticulous hemostasis is mandatory.

Postoperative complications are directly related to the severity of the underlying polycythemia and the effectiveness of its control. Since bleeding is more common postoperatively than thromboses, the routine use of heparin postoperatively is not advised. Major surgery in patients with poorly controlled polycythemia carries a 25 per cent mortality rate and serious complications in an additional 50 per cent.²

Dextran is useful postoperatively to reduce platelet aggregation and decrease chances of thrombus and embolus formation. The high evidence of gout, which occurred in our first case and is stated to occur in 5 per cent of polycythemics, is explained by the rapid turnover of blood cells resulting in an increase in uric acid, an end product of nucleoprotein degradation.¹

It is the additional responsibility of the surgeon to insure that the patient with polycythemia vera is placed under the care of a hematologist or other physician who is experienced in the medical treatment of this disease. From all accounts, it appears that the definitive treatment of polycythemia vera is at present in a state of flux. Conflicting opinions

regarding the natural course of the disease and the optimum treatment are held by various investigators. On the basis of available evidence, radioactive phosphorus and/or chemotherapy (busulphan, chlorambucil, melphalan, cyclophosphamide), supplemented by phlebotomy would appear to be the treatment of choice for most cases of polycythemia vera. Phlebotomy alone may suffice in mild cases. Also, phlebotomy alone should be tried in young women of child-bearing age, at least until the significance of reports of chromosomal aberrations associated with myelosuppressive therapy are further evaluated. Any form of therapy, it should be emphasized, is necessarily anticipatory and should be subject to reappraisal as the condition progresses.⁵

Summary

Polycythemia vera is a rare disease; but vascular

complications, intravascular thromboses, and bleeding tendency are relatively common. The correct preoperative diagnosis and control of hypervolemia and thrombocytosis before and after surgery is emphasized.

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*A philosophical discussion of today's
"scene" in the light of
yesterday's experience.*

Beyond Good and Evil,

or

How to Create the Dark in Which to Whistle

MARK D. ALTSCHULE, M.D.,* *Boston, Massachusetts*

THE TITLE OF THIS SYMPOSIUM mentions values but it does not require that the speakers make value-judgments. When physicians consider their patients' illnesses they do not make moral judgments concerning them. Accordingly I shall not discuss any of today's revolutionary changes in terms of their possible morally good or evil effects or attributes. If on occasion my words have the appearance of adverse comment this is only an appearance. For the most part my feelings will not be identifiable, if at all detectable, and I suggest that you waste no time in searching for them and in attempting to relate them to my childhood experiences, or to what is more serious, to the fact that I have forgotten my childhood experiences. What I shall say will be entirely descriptive and largely self-explanatory.

Before, however, discussing the revolutionary changes with which we are all familiar, it would be well to establish whether they lie in the field of morals or of manners. We shall define the first as those aspects of human behavior (including the verbal) that involve content, whereas manners involve form. Although content and form inevitably overlap, a general separation is possible.

Serious Problem

To start with a summary: One serious problem is "the ridiculous and deplorable softness of parents, slaves to the caprices of the immature. . . ." "Each gives his children an education superior to that which is suited to their social and financial status; so that children, despising the knowledge of their

parents, reject criticism based on the latter's experience. Accustomed to follow all his inclinations, and not accustomed to discipline and to contradiction, the child, having arrived at maturity, cannot resist the vicissitudes and reverses by which life is agitated. . . ." On the other hand "an undue severity—reproaches for the slightest faults, harshness exercised with passion, threats and blows, exasperate children, irritate youth, destroy the influence of parents, produce abnormal tendencies to disease." "The ties of marriage are mere pretenses, which are formed by the wealthy either for gain or to gratify their self-love, and which the common people neglect, through disdain for the clergy, indifference, and immorality. . . ." In recording medical histories information about whether the patients are married or unmarried is valueless because it in no ways bears on their behavior. "From a record kept for 10 years at several hospitals, one-third of the women admitted are very aged, paralyzed, and in senile dementia. . . . These infirm patients would formerly have remained in their families. . . . People avail themselves of an easy means of relieving themselves of the burden of their support."

These comments are descriptive of today's society; however they were made by a leading European physician of 150 years ago. Another physician, an American, who practiced and wrote 100 years ago made comments that are even more applicable to today's problems. He stated a century ago that American "social life scattered widely the seeds of distrust; developed precocious ideas of independence; and made youth familiar with evil before it was prepared to judge intelligently, and when it should be shielded by parental care." These evils, he said, "were but too plainly exemplified in the mental traits characteristic of young America and in the increasing stream of depravity, and disease both physical

* Presented by Mark D. Altschule, M.D., Clinical Professor of Medicine, Harvard Medical School, and editor of *Medical Counterpoint Magazine*, at the Cobb County Medical Society's Symposium '71—"America vs. America—The Revolution in Values," April 29-30, 1971. Permission to publish this paper, which appears in *West Georgia College Studies in the Social Sciences*, Vol. X, is granted by West Georgia College, Carrollton.

and mental, which permeated the social fabric, and threatened to injure not only the present but future generations." We may therefore immediately make two conclusions: 1) the views of a physician are likely to be different from those of philosophers and social critics, and 2) mankind has not changed much, at least in the last 150 years.

Revolution of Manners

It is evident to any physician that today's revolution is largely one of manners. This conclusion is most evident to a physician in a community with strong academic ties. No individual person that I may see now is doing or saying anything different from what a number of individual patients of mine did and said 40 years ago, with two notable differences. Although individual human behavior has not changed, there have been changes in the relative numbers of people engaged in different types of behavior. Moreover, although individual behavior has not changed in detail, group behavior has changed somewhat for reasons that will be discussed. In addition, evaluation of our behavior has changed markedly in that it has been given an unwarranted implication of moral change. This is owing to several reasons, the most important of which is that now behavior manifested by persons more than 25 years old is ascribed by some social critics to boring, stupid, or vicious motives, whereas all behavior of persons less than 25 years old is said by these critics to be motivated by truly humane, idealistic and honorable impulses, unless the behavior was distorted by the boring, stupid or vicious acts of people more than 25 years old.

In this connection it is interesting to note Dorothy Canfield Fisher's contempt toward those "who think that everything considered a virtue before they become sophomores in colleges is a middle-class betrayal of the best in human nature." (This appeared in her introduction to Crane's *Let Me Show You Vermont* published in 1937.) Today we recognize that a middle-aged man who intoxicates himself with the alcohol in liquor is making a disgusting brute of himself whereas a young man who intoxicates himself with the other alcohols in marihuana is undergoing an ennobling experience.

Early in their careers medical practitioners learn that people are all alike. (If people were not all alike physicians could not function.) Somewhat later in their careers physicians learn that all people are also different. (If they were not there would be no need for physicians and some machine could make diagnoses and recommend treatment.) Appreciation of the similarities and dissimilarities of people is the basis of all medical practice, regardless of whatever scientific data may be involved. In preparing to care

for a particular patient a medical practitioner must learn how his patient resembles and differs from other persons, and he does this by studying his patient's past life. In short, he must be an historian, and, in Plutarch's words, he must be "like the watermen who look astern while they row the boat ahead."

A sick society must be similarly studied if the causes of its malaise and its possible cure are to be worked out. The utility of history for this purpose has been denied by a segment of our population, and to some extent properly so. All physicians know that most of a patient's history is not relevant to the problem at hand; the physician must seek and select those items that lead to an understanding of the malaise, if there is one, or to an appreciation of the factors that may make an old illness seem new. Actually, it is impossible to avoid historical evaluations in discussing social ills. For example when we read: "We have changed our old usages in favor of speculative ideas and dangerous innovations. . . . There are no longer any domestic feelings, not of respect, not of love, not of authority," followed by the statement that 15 per cent of all persons in mental hospitals are students, we should know that the comments were made in 1838 by the world's leading psychiatrist, Esquirol, and not by some modern Cassandra.

Deplorable Behavior

Rather than multiply and amplify such generalities we shall limit ourselves to a few specific aspects of behavior that many today deplore. For example, as regards the hippies, the Epistle of Jude stated, "These filthy dreamers defile the flesh, despise dominions, and speak evil of dignities." It is, however, impossible to know today whether this actually referred to hippies. Perhaps a more explicit statement might be more illuminating. Another author wrote ". . . A youth approached me. He was bearded; his clothes were dirty; he wore a student's cloak and he looked a typical New Cynic of the sort I deplore. I have recently written at considerable length about these vagabonds. In the last few years the philosophy of Crates and Zeno has been taken over by idlers who, though they have no interest in philosophy, deliberately imitate the Cynics in such externals as not cutting their hair or beards, carrying sticks and wallets, and begging. But where the original Cynics despised wealth, sought virtue, questioned all things in order to find what was true, these imitators mock all things, including the true, using the mask of philosophy to disguise license and irresponsibility. Nowadays, any young man who does not choose to study or to work grows a beard, insults the gods, and calls himself Cynic." This was written by the Emperor

Julian in the fourth century A.D. Perhaps this is too remote in time of place to be—to coin a cliché—relevant. Let us turn to another author who wrote about people who were recognized by their “taciturnity and downcast looks, a total neglect of dress and person, long nails and beard, dishevelled and matted hair, indifference to surrounding objects, insensibility to heat and cold. . . . Such persons seek for, rather than shun human society. Sometimes they wander through neighborhoods in the capacity of beggars. . . . There are some instances in which the moral faculties are impaired, in which case they are mischievous and vicious, but they are more generally inoffensive, and disposed to be kind, and even useful, in hospitals and families.”

These words are not from some modern writer's description of hippies; they were written by Benjamin Rush of Philadelphia in his discussion of what he called “partial insanity,” published in 1812. (I believe that his clinical diagnosis was correct.) At any rate it is clear that the pursuit of hippiness is not new, and that the relation of drug abuse to today's hippy behavior is not an essential one.

As in earlier times, today the desire to legitimize avoidance of responsibility prevails among many inadequately educated persons who use fragmentary and distorted knowledge to disguise their aims. The wish to be free of all responsibility is probably as ancient as man, but good records regarding this matter go no further back than the Greco-Roman era. For example, Seneca said, “To make a man happy, add not to his possessions, but subtract from the sum of his desires.” These words were merely a paraphrase of what Stoic philosophers and their Oriental precursors had been saying for generations. The ancient idea that peace of mind can be attained only by not striving for property, position, or power is still popular today. It implies that the effort of securing or maintaining any of these materialistic goals produces unbearable uncertainty and disappointment as well as destructive changes in the personality. This view holds that when finally the goals have been reached—if they ever are—they prove to be not only a nuisance to maintain but so boring in themselves as to increase the dissatisfaction that originally had led to the pursuit. The youth of the Classical Era who absorbed the teachings of the Stoic and then the Cynic philosophers believed that those who lived according to these philosophies were a fellowship of superior souls, not bound by family ties; they were the only ones who were happy, free, beautiful, and truly wealthy. These happy few maintained that they were also emancipated from all moral laws. All other men, according to these ancient philosophies, were

mad or wicked creatures who wasted their lives as slaves to conformity. These ancient philosophies seem to have a perpetual appeal.

Drug Scene

What about the drug scene? We shall not refer to the lotus-eaters, or to the men changed into beasts by Circe, nor shall we mention that Charlemagne took hallucinogenic drugs, or that the Holy Roman Emperor Henry IV became permanently insane when his wife gave him drugs for erotic reasons. Nor is there any need to refer to the fact that what is today called the witchcraft epidemic of late medieval Europe evidently was an epidemic of drug abuse, and the descriptions of what witches did were based on delusions and hallucinations. This was pointed out by Foderé in his *Traite du Delire* in 1817 and more recently by Barnett, in the *New Scientist*, July 22, 1965. The main drugs used were apparently of the stramonium-mandrake group, similar to the Asthmador used by today's drug abusers. Since according to current views of history these remote events cannot possibly have any relevance for us today, let us turn to others. In one country, in the decades following a long and bitter (and probably useless) war, 5 per cent of the population became addicted to morphine; this was our own Civil War. The widespread opium addiction of the late Georgian and early Victorian eras is better known. The pattern of drug abuse has however changed. The abuse originally seems to have been related to affluence. For example the psychiatrist Sir Charles Ellis wrote in 1830: “The ultimate effects produced upon the nervous system from taking opium to excess are very similar to those which arise from spirit drinking; but this vice is not one generally committed by the lower orders.” Today anybody can be a drug abuser, and this clearly represents social progress. Drug abuse is a most common cause of death in young people in America. Moreover in some cities, the number of men of military age dying of drug abuse in one year exceeds the number of men from that city killed in the entire Vietnam conflict. It is ironical that some of those most violently opposed to the war are equally vigorous in their attempts to make drug abuse easier. The cure of drug addicts under 25 is virtually impossible, and of addicts over 25 statistically disappointing. Hence, as in dealing with an infectious epidemic disease, prevention becomes most important, but this is impossible in our permissive society.

Why has drug abuse always been so persistent a human practice? Let us consider some biological observations: If monkeys are connected to an apparatus that injects intravenously a measured amount of a drug when a bar is pressed, the animals will press

the bar frequently in order to receive morphine, pentobarbital, ethyl alcohol, cocaine, or amphetamine but not some other drugs. In the self-administration of alcohol malnutrition is a frequent complication. Cocaine causes "the most frightening picture. After one injection experience, the monkey will self-administer the drug until he dies in convulsions." (See Seevers, M. H. *Laboratory Evaluation for Drug Dependence*. In *New Concepts in Pain and Its Clinical Management*. E. L. Way, Ed. Philadelphia, Pa.: F. A. Davis Co. 1967.) Does the monkey thus become a drug addict in order to escape the stresses of his daily life? Does he have a death wish? Does the monkey wish to extend his mind? Or are these currently popular romantic psychologizings nonsense? Perhaps the best answer to this question is provided by Sir Humphrey Davy's report almost a century and a half ago. He inhaled nitrous oxide and experienced an awe-inspiring revelation of the secret nature of everything in the universe. He wrote it all down, and after recovering from the effects of inhalation, hastened to read what he had written. The words said: "This stuff has an awful stink." Despite Sir Humphrey's disappointing experience young people of his time, including many college students, continued to have ether parties or laughing-gas parties as a lark.

Illusory Benefits

Actually the fact that the alleged benefits of psychedelic drugs were illusory seems to have been recognized centuries ago. One account of the Garden of Eden events is to be found in an old English poem, today called *Genesis B*. (See *Speculum* 44: 86, 1969.) This table describes how the Serpent promised Eve that if she ate the fruit of the Tree of Knowledge she would be granted the sight of heaven and of the throne of God. She did eat the fruit and she did have the vision, which she described in words of exaltation and joy. Heaven and earth seemed brighter to her, she could see for great distances, and wherever she looked light shone brightly before her. (The vision of Heaven she experienced is identical to other described visions of the Last Judgment.) The account indicates that Eve did not really see all these things but only believed she did. At any rate she used the promise of the vision to tempt Adam to eat the fruit. Adam ate it but had no vision, and when the effects of the fruit in Eve had worn off they both recognized that they had been ruined. Although Eve's action had been in good faith their punishment proceeded. Regardless of which plant history proves to have led to Eve's hallucinations in the Garden, the event itself foretold what today seems to be a frequent occurrence, the ruin of a young person by a friend, lover, or spouse who in-

duced him or her to try a drug through the promise of a beautiful experience.

What about the cannabis group, marihuana and hashish? Predictions of the future status of cannabis can be made only through extensive study of its past history. Most current accounts refer only to its use by laymen as an intoxicant; this use, or at least the sale leading to this use, is now illegal in most countries. However cannabis (as tincture of cannabis) was considered a valuable medication in the nineteenth century for the treatment of maniacal patients in mental hospitals. These patients had not only great strength but great cunning, and the tincture was given to make them both docile and stupid. It was included in the form of the extract and the fluid extract in the U. S. Pharmacopeia as an official drug up to 1930 but, since there was no way in which it could be standardized, it was dropped from it. Today its active principle is known, and hence should be used medically where tincture of cannabis was formerly employed. Since cannabis is effective when inhaled, its use as an aerosol by police attempting to control a mob is a possibility. Aldous Huxley's *Brave New World* describes an event of this sort: The police sprayed the unruly crowd with some substance that made the mob peaceful and full of happiness and love for everybody. Of course when the police begin to use the drug in this way, students will shun it.

Generation Gap

What about the generation gap? Is this new? Pinel around 1800 quoted La Bruyere as saying that "there are strange parents whose whole life seems to be spent in giving their children reasons to be consoled for their death." Pinel added: "The public houses of correction, and the asylums for the insane are constantly furnishing examples suitable to serve as commentaries on this text. How often do we see bitter reproaches for the slightest faults—harsh words uttered in the voice of anger—nay even threats and blows—exasperate a hasty youth, break through all the ties of blood, produce the most abnormal disposition, or precipitate the sufferer into serious madness." On the other hand Shakespeare said: "How sharper than a serpent's tooth it is to have a thankless child." In fact it is traditional for the elders to complain about the youngsters. For example in ancient Greece Socrates said: "Children now love luxury. They have bad manners, contempt for authority. They show disrespect for elders, and love chatter in place of exercise. Children are now tyrants. . . ." (Socrates was evidently referring to city children; he seldom left the city, saying "Field and trees teach me nothing, but the people in a city do.") In a slightly more modern era, this behavior

was described as owing to the children's insecurity. For example, one author of several decades ago, John P. Marquand, in Chapter III of his book *Life at Happy Knoll*, ironically ascribes all sorts of teenage rowdiness and general misbehavior to young people's search for the security of which society has deprived them. The discovery that they are considered to have been made insecure by our imperfect society has been one aspect of social progress that has been a boon to teenagers. Of course the ancient Greeks did not know that young people acted that way because they were insecure—which shows how much the world has progressed since then.

Successive generations have always regarded each other as peculiar and to some extent difficult. However, although the exteriors differed, the generations were usually regarded as internally alike, at least by the elders. These ideas were well described by the poet Cowper, in a letter to Unwin, his friend: "When we look back upon our forefathers, we seem to look back upon the people of another nation, almost upon creatures of another species; we can hardly believe that a people who resembled us so little in their tastes, should resemble us in anything else. But in everything else, I suppose, they were our counterparts exactly; . . . time . . . has left human nature just where it found it. The mind of man, at least, has undergone no change; his *passions*, *appetites*, and *aims*, are just what they were; they wear perhaps a handsomer disguise than they did in the days of yore, for *philosophy* and *literature* will have their effect upon the exterior, but in every other respect a modern is only an ancient in different dress."

This benign view of things is far from universal today. Although a certain amount of conflict between generations is to be expected, today we seem to have an excessive amount of it. Some conflict between generations is inevitable, since a generation that grows up in a given social or physical environment knows no other, and inevitably takes a different view of it from that taken by an older generation that had to adapt itself to an environment that was new to it. This revolt of the young against their elders has always taken one of several forms, and has always been justified by basing it on idealism, freedom, and the preservation of individuality. The last is most strongly emphasized and gives rise to the same so-called individuality among the entire generation. This collective individuality is not individuality at all but is merely conformity carried to excesses of hypocrisy. Nevertheless these mass movements of pseudo-individualistic young people with their restless energy and strong idealism may accomplish good, either as such or by calling emphatic attention

to things that need to be done, as many philosophers including Plato and Aristotle have pointed out.

Rebellion

On the other hand, the urge to be individualistic may deteriorate into mere unthinking rebellion: What should be a well-thought-out positive attitude becomes an uncritical negative position. This rebellion has repeatedly fallen into a few stereotyped patterns for a thousand years or more:

1. Delinquent behavior and disrespect toward parents, Shakespeare, in his "Winter Tale," summarized this: "I would there no age between ten and three-and-twenty, or that youth would sleep out the rest, for there is nothing in the between but getting wenches with child, wronging the ancients, stealing, fighting. . . ."

2. Favoring one's country's enemies (this must be distinguished from expressions of a desire for peace). The pattern is as follows: The students and faculties of the universities are sick of war. Although the enemy had been guilty of many atrocities the young academics ignored this and instead praise the enemy forces for their heroism and nobility. They describe their own country as a monster of imperialism ruled and ruined by a lot of old men—their parents—who are not only incompetent but wicked. This familiar pattern occurred, e.g., in the English universities in the 1920's and was described by Claude Cockburn in his autobiography, "In Time of Trouble."

3. Disdain toward established modes in fashion and the arts. This pattern is described, e.g., in *La Nevrose Revolutionnaire* by Cabanis and Nass (1906).

4. Derogation of accepted standards of cleanliness and neatness owing to a faked preoccupation with spiritual matters. St. Jerone (A.D. 340-419) described the Roman youth who claimed to have turned their backs on the materialistic world, affecting "hair as long as women's and beards as goats" worn in order to convince people of their wearers' spiritual superiority. He pointed out that if the relative length of the beard is an index of spirituality nobody is more spiritual than a goat. Paradoxically the denser the hair covering a face the easier it is to see through.

5. Contempt towards their elder's accumulated worldly goods because they are assumed to destroy spiritual values. After the death of Lorenzo the Magnificent the youth of Florence, activated by Savonarola's sermons, formed mobs to destroy the accumulated evidence of Renaissance worldly luxury. They attacked wealthy and cultivated men and women and burned books by classical scholars and the paintings of great artists. The movement ended

in severe repression by a new government. In other events groups of young men who had just completed their formal education settled in an abandoned house and decided to spend their lives in a freely-shared ascetic life seeking mystical awakening. This occurred in various places and at various times, for example in Venice in 1400.

Reasons for Gap

The reasons for today's excessively wide generation gap require elucidation. Shakespeare described this discord as a symptom of a weak social order. When in his *Troilus and Cressida* (Act 1, Scene 3) he has Ulysses say, "And the rude son should strike the father dead" he was describing what happened in such societies. We have to answer a question: If, as we have shown, the general patterns of human behavior have not changed in the two thousand years of recorded history, why is our social order so much weaker than some others? Stating that our order differs from the others only as regards quantitative and not qualitative aspects of behavior does not satisfactorily answer the question but it does give direction to the inquiry.

There is no need to multiply the examples that show the stereotype of human behavior; every physician knows that people are all alike. It is important to examine the factors that have produced the quantitative differences in what is basically stereotyped human behavior. These clearly fall into two main groups:

1. technologic changes
2. prevalence of superstitious psychologic and sociologic doctrines, including those that lead to faulty education.

Some Effects of Technologic Changes

There is no need to emphasize that technologic developments change behavior drastically. It is not our purpose to refer to such specific inventions as that of the electric guitar, that has made rock and roll music so great a cultural force, or the bull-horn, that essential instrument of social protest. We shall speak in more general terms.

The Industrial Revolution, during which machine power came to replace human muscular effort, started the process which has now reached a point at which the laborer is often merely a gadget attached to a machine or is a cog in a complicated administrative complex. The creative aspects of work have largely been lost and a vast boredom has supplanted it. The fact that boredom creates serious psychologic stresses has long been known to observers of human activity although largely neglected by modern psychologists and psychiatrists.

As Crichton, an early nineteenth-century English psychiatrist noted: "It is a favorite opinion with Helvetius and many other philosophers, the ennui is one of the most powerful motives in the mind of man which stimulates him to great actions. There can be no doubt of the general truth of this fact, only it is not quite accurately expressed; for it is the desire of relief from pain and not the languor from which the actions spring." These philosophers evidently believed that boredom, or the need to avoid it, is one of the most powerful motive forces in human life. (They differed with John Locke, who said that anxiety, or the need to avoid it, played that role.) (Today Locke's name is spelled Freud.) In everyday life physicians have the opportunity to observe how protracted boredom produces increasing restlessness, tension, and in some persons, anxiety. One of the effects of stress is regression in behavior patterns, so that previous patterns emerge. Hence boredom, like any other stress, induces immature and pre-social behavior.

Sexual Revolution

The recent technologic (including the chemical) revolutions have made sexual activity much less likely to have some untoward results than was true in the past. This has removed one important incentive to chastity and has helped to reveal the insubstantiality of virtue. (This is reminiscent of the medieval situation. In those days no lady could yield to a gentleman until he had proved his manliness in three armed conflicts. This made some men appear braver than they actually were and since many of the men did not survive the requisite three fights, it made many women appear more virtuous than they really were.) The technologic developments responsible for the improvement in contraceptive practice have permitted the development of the sexual freedom that prevails today in the so-called civilized world. They have permitted an unprecedented degree of enjoyment of venereal pleasures. Unfortunately they have permitted a prevalence of venereal diseases that makes them outrank all other infectious diseases in teenagers. The increase in teenage pregnancy, with its high rate of medical complications, is a paradoxical consequence of the sexual revolution induced by technologic changes.

Another behavioral consequence of the current advanced state of technology is the prominence of the Female Liberation Movement. No amount of philosophizing or of propagandizing could ever have advanced that movement to its present prominence but for the technologic processes that permitted women to have employment in industry, that filled the house with labor-saving devices, and that markedly reduced child-bearing. Whether or not any sig-

nificant number of women has formally joined some segment of the Female Liberation Movement is not under discussion here. What is meant, rather, is that technologic developments permitted women sexual freedom and partial escape from the demands of a mother's role. The sexual freedom has not by itself been as liberating to the spirit as was expected and the results have been experimentation involving the social organization of sexual behavior, e.g., spouse-sharing and group sex, and experimentation involving the physical practice of sex. Both have produced a sex-life devoid of its most elevating emotional aspects and conducive only to more boredom than they were intended to relieve.

Population Concentration

Worst of all is the fact that the technologic revolution has crowded people into cities and adjacent suburbs. Agriculture as a way of life that permitted people to exist spread out in the country can no longer exist. Also modern technology demands the creation of huge manufacturing centers and in consequence a concentration of population. At the same time man's innate search for anything that will permit decreases in the requirements for physical and mental effort has drawn him to the cities. These factors have emptied much of the country (a fact that escapes the notice of those who travel only by main highway) and has concentrated people into environments that have no precedent in primate biology. In addition to the problems of water supply, solid waste and sewage disposal and atmospheric pollution created when people cease to be dispersed and became aggregated—and these are bad enough—there are the worse problems caused by the effects of people on people.

Although animals with highly developed societies exist—and their rigidity and stereotype should not be ignored—primates living in nature comprise small and loosely organized social groups. The huge groups organized into complex societies that characterize today's highly industrialized cultures are of recent origin. In fact, permanent village life is probably no more than 10,000 years old. Contrast this with the millions of years in which social insect societies evolved and came to exist. It is evident that when human personalities come into contact each of them must lose some of its attributes. Compare the personality of any normally developed individual studied alone with the personality of a group of 10 and then of 100, and then 1,000. There is no doubt that the total is always less than the sum of its parts; the larger the number involved, the greater the difference between the total and the sum. This loss of per-

sonality is transitory, often briefly so and hence unnoticed, when a few people aggregate for limited periods. However when large numbers of people come together for extended periods, a serious persistent atrophy of their personalities occurs. This atrophy may be masked by the pace of interaction that may occur in aggregated populations but this interaction is simplified and stereotyped; in fact it is boring to watch and boring to participate in. The underdeveloped or atrophied personality is highly susceptible to boredom, and cannot escape from it. Lacking the personal resources for a stimulating existence, it can only seek the company of other personalities, many of which are similarly underdeveloped or atrophied, and hence, boring. A further atrophy of the personality, and increasing frequency and persistence of the boredom are the bewildering result, and it becomes more pronounced with advancing age. No wonder the young find most older people unsatisfactory but will follow any stimulating older person no matter how depraved or nutty he may be. The aging atrophied personality is capable only of simple stereotyped responses and hence is labeled conservative. This is not a correct use of the term—a conservative personality is not necessarily a stultified one and vice-versa. The increase in the prevalence of these undeveloped, atrophied or fragmented personalities has led to the need for a new form of social organization. With a lack of inventiveness that characterizes such personalities, they have adopted an old form and called it new—the commune. By fusing dozens of inadequate personalities the commune may create one or two good ones, as long as the components act in unison. Accordingly, commune living should be encouraged rather than derogated. It is the only solution for the vast numbers of imperfect personalities we have created.

Man as the Enemy

Another consequence of city living has, to my knowledge, been touched on by few if any sociologists. This is a change in the attitude toward people in general. To rural people *Nature* often exhibits inimical attributes: storm, flood, drought, frost, insect pests, etc. If these natural hazards exist at all in the city, they are so rare and so diminished that *Nature* ceases to be regarded as inimical and *Man* takes its place. Anything untoward that occurs to the city dweller can be blamed, rightly or wrongly, on the actions of other people. Hence, whereas the country dweller takes mankind as, in the words of John Quincy Adams, "as we take a wife—for better or for worse," to the city dweller every man who is not at the moment a friend is—at least at the moment—probably an enemy. This paranoid thinking is further stimulated by the involuntary togetherness

prevalent today. The paranoia often leads to a belief in witchcraft among the superstitious and of conspiracies (e.g., the Establishment) or familial malevolence (e.g., the mother as the cause of schizophrenia, the spouse as the cause of alcoholism, the children as the cause of senile psychosis) among the half-educated. This general attitude also leads to the fantastic belief found in children's fairy tales, the belief that some day soon the Final Battle between Absolute Good and Absolute Evil will occur, and the rich, bloated arrogant treacherous forces of Evil will be wiped out (except for the few who confess their error) by the ragged, starved, poorly equipped but unceasingly valiant forces of Good.

Our advanced technology has led to a habit of immediate gratification of all wants, with little or no effort. This habit, or at least expectation, is far more prevalent than it was a century ago. Immediate gratification and no toil could not possibly be widespread in the mainly agricultural society that then existed. The idea of planting, cultivating and, after considerable time, harvesting, prevailed in occupations and carried over to other matters of daily life. The number of persons who could legally exist off the surplus created by the toil of farmers was not large. These nonproducers instinctively limited their numbers by excluding, ostensibly for genetic reasons, those who wanted to join their number. Although the industrial revolution has permitted the harnessing of water and steam power for a variety of manufacturing processes, manufacturing as a whole still involved much direct contact between the worker and the object, and the transformation of raw materials into manufactures was still relatively slow and dependent on the effort of individual workers.

Life today is completely different in this country. Agriculture is a way of life for only a small segment of the population. Those who today participate in industry do not see the gradual transformation of raw material into finished product. They are more closely in contact with some machine than with the product it is helping to create; in fact are more likely to think and act like attachments of machines than like the creators of products. Moreover, the development of electric power and of electronic regulating devices has made man even less of a participant in the creation of things he uses than he was a generation ago. These and other recent developments have produced an entirely different pattern of behavior from that which previously prevailed.

New Behavior Pattern

Today's persons less than 30 years old were brought up conditioned to respond to most wants, both physical and mental, by pressing buttons, ripping open cans, dissolving concentrates, thawing fro-

zen food or drink, spraying a mist on some surface alive or inanimate, etc. The idea that at least the onset of gratification might be delayed as much as 30 minutes is enough to make a person start hiding candy bars under his mattress.

As John Reid said in 1816: "Expectation is the vital principle of happiness. It is that which constantly stimulates us to exertion, and fills up the vacant spaces of life. We are in general more interested by a precarious good in prospect, than by the most valuable realities in our possession. The blossoms of hope are better than the ripened fruits of fortune. We complain of the vicissitudes and uncertainty attending upon our present state, and yet as it is, in this very uncertainty and vicissitude, that its interest, and of course its value, principally consists. Anticipated changes constitute the predominant charm of life." This has been largely lost.

Today's era of electronic gadgetry has had another effect: it has not only created the delusion that immediate gratification is the normal way of life for everyone but it has also created vast surpluses that seem to justify this notion. The effects of these economic factors have been reinforced by current American theories of child-rearing which theories hold that anything restrictive is bad.

Affluence Creates Problems

The affluence produced by the recent technologic revolution has also created problems. The idea that poverty is bad and hence affluence must be good is one of the inanities of current sociologic thinking. Huge efforts are currently being made to eliminate poverty, because poverty has evidently demoralized many people of all ages, especially those under 25 years of age. It is equally evident, however, that affluence has also demoralized many people, especially those under 25 years of age. In fact as the affluent segment of the population becomes more numerous, the demoralization produced by affluence becomes more evident. We unfortunately have no great body of current writing on the sociologic disorders produced by affluence although psychiatrists of earlier eras did have much to say on this subject. It is clear that affluence spoils particularly when it is combined with permissiveness. For example, Sir Charles Ellis, superintendent of the mental hospital at Wakefield, wrote (1838): "When in early life the inclinations have never been thwarted, and the passions have been allowed to remain unsubdued, the disappointments and reverses of fortune, which almost invariably attend every human being in his passage through the world, frequently cause overanxiety in the mind, before unaccustomed to restraint." Conolly wrote (1830): "Mental ease is destroyed by the want of those privations and difficulties of which the

operation is always beneficial, though seldom duly appreciated" even when the person is distracted by the excitements of life in a large city.

Although it would be absurd to declare that technologic advances and affluence can only be evil, it is difficult to say any such thing about permissiveness in child-rearing. A permissive upbringing is widely recommended as a means of preventing personality disorders. However, permissiveness is, in fact, one of the most subtle and extreme forms of rejection.

It is at least as important as excessive harshness in separating parents and children. Another behavioral consequence of parental permissiveness is the spread of antisocial phenomena, phenomena that interfere with or even interdict those social processes that favor the maximal development and operation of the personality attributes of all the members of the community consistent with minimal impairment of particular personality attributes of any of its members. This is true because the demand for permissiveness is a demand for abdication of judgment in social affairs, and derives from the absurd notion that since there is no such thing as an absolute standard then there should be no standards at all.

Prevalence of Permissiveness

The reason for the prevalence of permissiveness in our society is hard to define. The philosophy that underlies it evidently originated in the writings of Rousseau. In his defense—and he is not an easy man to defend—he did not believe that his theories of child-rearing should be universally applied; he intended them to be used only by the upper classes. Since at that time these classes were numerically insignificant, his theories could not lead to a serious collapse of society. However, his philosophy became one of the main components of modern American social science. Today the so-called social sciences have come to dominate all aspects of mental life in this country. As that outstanding social scientist Professor Martin Gross pointed out in *The New School Bulletin* five years ago, they have gained in the colleges power of "magnificent, and undeserved proportions. The typical university curriculum is heavily weighted in the social sciences. . . . It might be said, without too great a fear of exaggeration, that the modern undergraduate is a social science addict. In the community outside the campus, the social sciences exert an impressive influence in such institutions as free public education (through educational psychologists and educators), welfare, penology, probation, social work, family and child guidance, adoption, numerous manifestations of psychology and

psychiatric care, work with delinquents, and massive federal programs of every variety, from poverty to race relations. . . ." This enormous expansion of a need for practitioners of the social science led our educational system to turn out large numbers of mediocrities in this field (as in some others). As de Tocqueville observed, "A middling standard is fixed in America for human knowledge. All approach to it as near as they can; some as they rise, others as they descend." The general tendency of American education to produce mediocrity, acting upon a branch of learning notable for its vagueness of formulation, disregard of rules for interpreting data and validation of method, and bizarreness of some of its leading thinkers had produced a vast number of educationalists who have created a crashingly erroneous concept of the nature of man and the goals in his education.

In passing, it might be noted that the harmful effect of philosophies has been a matter of comment since earliest days. Athenaeus told how Antiochus Sidetes, a Syrian king of the second century B.C., wrote to one of his officials: "We have already directed you that no philosophers shall stay in the city or district, yet we hear that there are not a few, and that they debauch the young, owing to my orders not being carried out. Upon receipt, therefore, of this letter, issue a decree to expel all philosophers, threatening any youths found in their company with hanging, and their parents with gravest censure. Let there be no mistake about this." Similarly, the Roman Senate, in 161 B.C., passed a decree expelling philosophers on the grounds that they were corrupting Roman youths to abandon their parents, traditional habits of thought and ways of life.

Today's popular philosophies deny the importance of contact between successive generations either as such or through their works. In so doing they ignore the biological nature of man. As Cassirer has pointed out, man is a "time-conserving animal" because man consciously and unconsciously uses the past experience of his species more than does any other animal; indeed, as far as is known, only man has developed history as a scientific discipline and a literary mode. To put it in more general terms, man as a biologic organism seeks the consolation of certainty in tradition at the same time that he seeks the consolation of hope in change. He conserves the past but flavors it with anticipation of the future. To assume that man can create a future while ignoring, or actually by rejecting, the past is the height of biologic absurdity.

Lessons of the Past

The lessons of the past are useful because they maintain social forms that are of proven value—ei-

ther as guides to behavior, as examples of beauty enjoyed by all, or as inspiring reminders of some great events in people's history. In addition, of course, the traditions created by past experience help to give culture the unity that binds different ages and different social groups so that the culture may survive. Traditions should be questioned because conditions change. Moreover, traditions are often a poor guide in making cultural changes required by changing conditions. Adherence to tradition may submerge new modes that clearly should be adopted; this happens because men find it difficult to believe in—or even notice—the unfamiliar while the familiar is constantly before their eyes.

The decision when to modify or abandon a tradition is a difficult one. Impatient and foolish men solve this problem by advocating the overthrow of all traditions. This suggestion may be advanced either as having practical ends or as a way of “liberating the spirit”—whatever that means. The indiscriminate overthrowing of traditions has always had unfavorable results. It is clearly not in harmony with man's biologic nature. The two opposing forces implied in the wish to preserve tradition and to institute change underlie all human social life.

It is evident that man's biologic nature, that of a time-conserving animal, must use both the past and the future. (The present is only a point in time and strictly speaking has no duration.) The radical ignores most of the past in planning for the future and hopes to create a static Utopia. The reactionary wants to return to the modes of the past, even though they have ceased to work and, in some cases, have been rejected by society. He too hopes to create a static Utopia. Accordingly, neither radicals nor reactionaries are time-conserving animals. The truly time-conserving man must pay equal attention to both the past and the future: he must therefore always favor things as they actually are—i.e., constantly changing through the fusion of useful old traditions with the new ideas for the good of the future.

Fanatical Allegiance

Unfortunately those young people whose peculiar education conditions them to believe that there are no valid standards, that only feelings should determine actions, and that the beliefs (and feelings) of any who differ with them are irrelevant are clearly unable to maintain, and much less to build a just and orderly society. It is unfortunate that all that some young people have acquired is little more than these notions from the education that we have provided for them. The fanatical allegiance to their own group that many of them exhibit is not praiseworthy. Exclusive loyalty to an immediate group prevents the growth—or survival—of any larger social organiza-

tion. It prevents social coherence and may lead to pointless conflicts characterized by a meaningless alternation of victories and defeats. A higher loyalty, to society as a whole, must outweigh all limited allegiances. Loyalty is the cement of a social system, much more so than any system of laws. All those who comprise a social order—and two social orders cannot occupy the same place at the same time—must be loyal to each other.

It is evident that if we apply the word revolution to recent events in this country, in most cases the word should mean going in circles. This circular phenomenon, with its recurrence of the same types of event, is freed from complete stereotype mainly through social changes introduced by the accidents of technologic discovery. Moreover, much of what we call the revolution in moral values today is merely a revolution in manners. In large part this change in manners is due to the change in the proportion of affluent in society. Since there are many more of them, their defects in behavior are more noticeable. The only real revolution in manners that has occurred is the rejection of privacy and at least outward respect for the rights and comfort of others together with the stated wish to be offensive to all persons, friend or foe (and this includes offending the senses of hearing, sight and smell). The issue has become confused because this revolution in manners is not only excused as a consequence of a moral revolution but actually claimed to be such a revolution. This is an attempt to give it an elevated status that it does not deserve. Today's revolutionary changes in behavior cannot be judged in terms of moral good or evil. For example, the notion that considerate manners are mere hypocrisy is merely an attempt to justify inconsiderate manners on fake moral grounds. Those accustomed by poor education to use slogans as if they were great moral principles easily fall into this error.

Unfortunately this error has been reinforced and perpetuated because some men who claim high principles have adopted the notion that it is necessary to perform antisocial acts to gain a purported future good. The imagined good end has been used to justify the present means; however, socially desirable formulas become not indications of planned reforms but rather the battle cries of antisocial violence. When this kind of violence deliberately sacrifices the present for an imagined future, it always loses the future too. Violent behavior and its attendant dogmatism become the refuge of weak persons who lack the character to endure dissatisfactions long enough to eliminate them by democratic processes without replacing them with new (and worse) ones.

Antisocial Behavior

When men who claim high principles condone—or recommend—antisocial actions in the name of social progress, less highly motivated individuals are encouraged to pursue similarly antisocial behavior. Today, many antisocial acts are performed out of boredom by persons who lack the resources needed to initiate worthwhile engrossing activities. When such people lack ethical standards of behavior of their own and reject the guidance offered by moral leaders in the community, they easily fall into antisocial ways. Antisocial behavior undertaken to escape boredom leads to more—and more extreme—antisocial behavior.

The general decline in personal standards of behavior is largely due to educational practices of the last few decades. The Dewey-eyed theorists (John Dewey, that is), who established child-rearing practices, have failed to take into account the need for externally imposed discipline in children if self-discipline is to develop in adults. (Giving self-discipline the pejorative name “inhibition” is not only harmful, it is inaccurate. Self-discipline is voluntary and rational; inhibition is involuntary and irrational.) When a community’s leaders and their unthinking followers engage in antisocial pursuits, all the rascals are emboldened to do likewise. Hence the responsibility for widespread antisocial behavior lies with the leaders of the community. When these leaders encourage antisocial actions by word or example, the community deteriorates. Such leaders are therefore

not qualified to lead. Men of sense and tolerance instinctively work both for the present and for the future. In order to do so, however, they must borrow from the past, because borrowing wisely from the past strengthens the possibility of an improved future. Ignoring the past favors the perpetuation of disorder, the most ancient social condition, in which irrational slogans, senseless planning, and pointless destruction predominate. Accordingly, those who today claim to be the most revolutionary as regards the social system are actually the most reactionary. Contrariwise, those who today seem to be least revolutionary by advocating deliberation in reform and study of the past are, in fact, the most revolutionary. They alone can be responsible for whatever progress is made. What is equally important is that they will lead the community in the direction of progress without the setbacks produced by antisocial times. They will be acting in accordance with man’s biologic nature—the time-conserving animal.

It is easy to see how the development of affluence and urban crowding, the ascendancy of an absurd philosophy in sociology and education, and above all the confused thinking of persons widely regarded as community leaders have created the dark in which we now are. Let him who will whistle in it.

In 1688 Fontenelle wrote in his *Les Anciens et les Modernes*, “We are under obligations to the ancients for having exhausted almost all the false theories that could be formed.” The young of today should be similarly grateful to their elders; the young will be spared the impossible task of creating new false theories.

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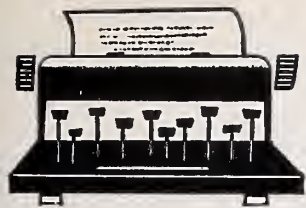
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Highlights of 1972 Georgia General Assembly

The following is a summary of some of the legislation of interest to Medical Association of Georgia that was considered during the 1972 session of the General Assembly. As of this writing none of these bills have been signed into law by the Governor. He has 30 days, excluding Sundays, in which to sign, veto or permit bills to become law without his signature.

HUMAN RESOURCES (H.B. 1424)—This portion of the Governor's reorganization proposal abolished the Board of Health, combined the Department of Health with the departments of welfare, vocational rehabilitation and several lesser agencies to create a Department of Human Resources. It created a 15-man Board of Human Resources consisting of five physicians, two health-related people and eight laymen. The bill further provides for a division of mental health separate and apart from the division of physical health.

The Governor has indicated in private discussions that he will include a pharmacist and a dentist among the non-physicians appointed to the Board. MAG will participate (by statute) in a Medical Nominating Committee to select 25 physicians from which the Governor must choose five for appointment to the Board of Human Resources. A copy of the House and Senate voting record on this matter may be obtained from the MAG Headquarters Office. PASSED.

CHIROPRACTIC (S.B. 474)—This bill would have compelled all health and accident insurance policies to include reimbursement for services rendered by chiropractors. As introduced, the bill also covered Workmen's Compensation and Medicaid. Medicaid, however, was amended out of the bill in the House Committee. S.B. 474 passed the Senate 31 to 9, was favorably reported from the House Insurance Committee, the House Rules Committee, and very narrowly defeated on the floor of the House (approximately 15 minutes prior to midnight adjournment deadline on the last day of the session). In the House all bills must receive a constitutional majority of 98 votes to pass. The chiropractic bill received 96 votes—just two short of the magic number. The chiropractors, encouraged by their "near win," are certain to reintroduce their bill again next year. They will have had an opportunity to lobby for their bill during a campaign year and MAG must expect another strong push to enact this legislation. House and Senate voting records on this bill may be obtained from the MAG Headquarters Office. DEFEATED.

PHYSICIAN'S ASSISTANT (H.B. 1591 & 1592)—H.B. 1591 was a technical bill to authorize certain people to engage in the limited and controlled practice of medicine without a license to practice medicine: In short, an exception to the Medical Practice Act. H.B. 1592 is the bill that actually creates physician's assistants as a new category of health care personnel. A copy of the full bill will be made available to a House of Delegates Reference Committee for their study. Points of significant interest in this bill are:

(a) Definition of physician's assistant is "Physician's assistant means a skilled person qualified by academic and practical training to provide patients services not necessarily within the physical presence but under the personal direction or supervision of the applying physician."

EDITORIALS / Continued

(b) Applications to utilize a physician's assistant shall only be made by licensed M.D.'s or D.O.'s to the Board of Medical Examiners and must include a description of the physician's practice and the way in which the assistant is to be used.

(c) No physician shall have more than two P.A.'s in his employment any one time.

(d) P.A.'s shall be authorized to perform their duties only in the principal offices of the physician with whom they are employed. However, they may be used to make house calls, and conduct hospital rounds.

(e) MAG efforts to amend the bill to restrict its application to those physicians engaged in private practice failed. However, we were able to secure an amendment to restrict the use of P.A.'s by public health physicians to those engaged in treating patients— administrative physicians could not employ P.A.'s.

(f) The Board of Medical Examiners is authorized to adopt rules that will exempt qualified medical employees from this act when they are performing functions permitted by law or custom. PASSED.

INTERNSHIP (H.B. 548)—MAG sponsored legislation (carried over from last year) that permits the Board of Medical Examiners to accept a clinical training program other than an internship as a condition of licensure. PASSED.

ABORTION (H.B. 647)—A substitute abortion bill which incorporated all the points agreed to by the 1971 House of Delegates (except restricting procedure to JCAH only) was favorably reported from the House Health and Ecology Committee. It was subsequently defeated on the floor of the House. DEFEATED.

DOCTOR-OF-THE-DAY—This program continues to draw warm praise from members of the House and Senate and remains MAG's most visible public relations endeavor. Your Committee on State legislation wants to take this opportunity to sincerely thank all those who participated in this program, and in particular wishes to extend its appreciation to Drs. Charles Watkins and James Kaufmann, co-chairmen for the project.

In addition to these bills, MAG followed with great interest legislative proposals in the following fields: optometry, clinical laboratories, hypnosis, licensure and control of ambulance services, and others. A full accounting will be given to the MAG House of Delegates and subsequently published in the June issue of the *Journal of the Medical Association of Georgia*.

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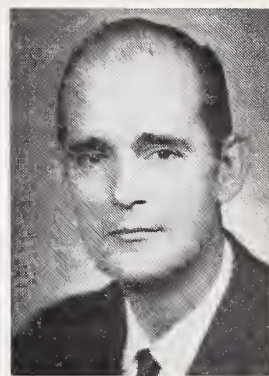
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WILL YOU BE READY?

THIS MONTH I ASSUME THE HIGHEST OFFICE in the Medical Association of Georgia and I want to tell you one and all that I am grateful to you for the honor which you have bestowed upon me and will try to perform the arduous task which the ever increasing workload of the Presidency of the Medical Association of Georgia has become, with diligence and hopefully with wisdom and inspiration. I must tell you from the beginning that the outlook for the future to me for organized medicine is a very grim one indeed. It is not because the health problems of the nation are growing worse, because they are not. It is not because doctors are in the highest paid profession known to man, because they are not. It is because the issue of health has become a political football in which little and big politicians seek to seize an opportunity to make a local or national name for themselves at the expense of the medical profession. I believe we are in the unfortunate situation in organized medicine that no matter how good we are, no matter how inexpensive we are, no matter how much peer review we do, no matter how much postgraduate education we have, that all of these things are not going to be enough to satisfy power-greedy, headline-hunting politicians.

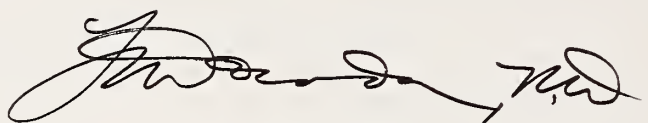
Now, I don't want to condemn all of the legislators, because we have some fine representatives at a national level and some fine representatives at a local level who understand the problems of health care delivery and health care financing and are trying to work with the medical profession to solve these problems rather than against them. To these people we should be eternally grateful and I do hope that these men of reason, wisdom and good judgment will prevail in the local and national legislatures—for if they do not, we are surely headed within the next five or six years toward an eyeball-to-eyeball confrontation with the political forces of the country.

How must we prepare for this? Number one I have already mentioned above. Those legislators at a local and a national level who understand and are truly indeed trying to solve problems and not grab headlines or grab higher political office—we need to work with them to try to solve the problems that indeed do exist in health care delivery in this country. Number two is, we need to put our own house in order and this is where your Georgia Medical Care Foundation comes in. Through its peer review activity we are able to help eliminate wastefulness, unjustified and unnecessary injections, unjustified and unnecessary office visits and unjustified and unnecessary hospitalizations or length of hospitalizations and we are able to eliminate the problem of unjustified maintenance of patients in nursing homes at a skilled level of care when a lesser degree of care will do.

This is the first thing that the Foundation will do, but it is to me the least valuable of the services the Foundation will perform. The Foundation cannot only help us validate our practice methods that we are currently using, but they can

help the Medical Association of Georgia solve the problems of maldistribution of physicians, the accessibility of medical care to patients and it can also help control ever-spiraling health care costs by re-distribution of the health dollar in which more and more of the patients are seen in the doctor's office and in non-institutional settings if this is done. One certainly must be aware of the fact that this type of medical practice is harder and more demanding on the physician and more hazardous for him than is the liberal use of institutional care, and third party payors of all varieties and ilks must be ready to compensate the physician at a rate that is indicative of the increased difficulty and the increased hazard which the physician experiences.

Is confrontation in the future necessary? I hope not, if we do our homework as mentioned above. We must, however, be prepared for its eventuality.



*F. W. Dowda, M.D.
President, Medical Association of Ga.*

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I agree to continue membership and to support the Bylaws, Articles and philosophy of the Georgia Medical Care Foundation, Inc., for the fiscal year, June, 1972 to June, 1973.

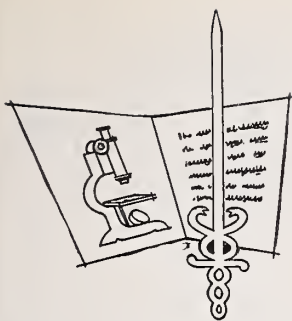
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LOOK CLOSE TO HOME

DANIEL B. SULLIVAN, M.D., *Augusta*

THE DEATH RATES FROM CANCER in the United States have shown a slow but steady overall increase in the past 30 years.

There have been isolated variances: namely, stomach cancer, once a leading cause of death in males, has shown a definite decrease. Cancer of the colon and rectum has shown a slight increase, but has leveled off recently. Cancer of the uterus has been coming down and this is probably the result of earlier diagnosis with the use of Papanicolaou's smears.

The remaining solid tumors, including breast cancer and the leukemias, have remained relatively stable.

The striking and startling change has been the tremendous increase in cancer of the lung in males and females.

The usual personal evaluation of such statistics is that: "This may be true nationally, but it probably isn't happening in our locality. It certainly is not apparent in Georgia, or more specifically, Richmond County." This, of course, is a rationalization and it is as true for the population in Richmond County as it is for the nation.

Incidence of Lung Cancer

I recently reviewed the audits of the University Hospital for the year ending in 1942 and one of the many interesting things was the fact that out of 223 new cancer cases, only four had lung cancer.

I thought it might be interesting to ask the record department of the University Hospital and St. Joseph's Hospital in Augusta just to look up the number of bronchogenic carcinoma patients admitted to each hospital for the year of 1971.

This is not a complete analysis and it does not necessarily mean the new patients that year, it is the number of people admitted in the year 1971 with a diagnosis of bronchogenic carcinoma in the two hospitals. The University Hospital had 91 patients with this diagnosis in 1971 and 11 were admitted to St. Joseph's Hospital; of this total number of 102 patients with a diagnosis of bronchogenic carcinoma, 78 were males and 24 were females.

This in itself is amazing since carcinoma of the lung in females was almost unheard of 30 years ago.

The number dying of this disease was 27, 18 males and 9 females. This is well within the pattern of the tremendous increase in lung cancer and to see an increase from four cases to 102 cases in a 30-year period is well out of line with the rates of occurrence of any other neoplasm.

The statistics, of course, cannot be ignored and it is interesting to note that the majority of these individuals came from rural and not large urban areas of this part of the State of Georgia. Those of us who deal with tumors every day cannot escape the obvious facts of the relationship of the tobacco leaf to the increasing rates of bronchogenic carcinoma.

1467 Harper Street

THE ASSOCIATION



NEW MEMBERS

Andrews, James R. Associate—Muscogee—Or	Medical Center Columbus, Georgia 31901
Casas, Osvaldo Active—Baldwin—GP	Central State Hospital Milledgeville, Georgia 31061
Delgado, Jose A. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31061
Duhon, Fred J. Active—W-C-D—GP	Doctors Clinic Lafayette, Georgia 30728
Glassman, Armand B. Active—Richmond—Path	Medical College of Georgia Augusta, Georgia 30902
Greene, Ralph R. Active—W-C-D—GP	P. O. Box 460 Ringgold, Georgia 30736
Hansen, Richard A. Active—W-C-D—GP	Wildwood Hospital Wildwood, Georgia 30757
Huber, Douglas C. Active—Baldwin—Path	Baldwin County Hospital Milledgeville, Georgia 31061
Johnston, Joseph F. Active—Richmond—Anes	Medical College of Georgia Augusta, Georgia 30902
Lesslie, William P. Active—Cobb—I	86 S. Cobb Drive Marietta, Georgia 30060
Lott, Thomas M. Active—Glynn—R	3010 Hampton Ave. Brunswick, Georgia 31520
Quillian, Willard E., III Active—Richmond—P	Medical College of Georgia Augusta, Georgia 30902
Ravelo, Humberto C. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31061
Rhame, Donald W. Active—Bibb—Su	700 Spring Street Macon, Georgia 31201
Robertson, Alex F. Active—Richmond—Pd	Medical College of Georgia Augusta, Georgia 30902
Slate, Robert W. Active—Stephens—Su	800 E. Doyle Street Toccoa, Georgia 30577
Smith, Stuart A. Active—Floyd—Oto	14 Hospital Circle Rome, Georgia 30161
Tyrone, Nelson O., Jr. Active—Muscogee—U	Doctors Building Columbus, Georgia 31901
Utset, Bernardo B. Active—Baldwin—GP	Central State Hospital Milledgeville, Georgia 31062
Waters, Raymond O. Active—Floyd—Oto	14 Hospital Circle Rome, Georgia 30161

SOCIETIES

The **Bibb County Medical Society** had Dr. Juan A. del Regato as their M. J. Witman Memorial Lecturer at their March meeting. Dr. Regato is director of the Penrose Cancer Hospital, Colorado Springs, Colorado, and is one of the world's foremost specialists in Radiologic Therapy.

The **Georgia Medical Society** co-sponsored a meeting on pollution with the Junior League of Savannah in March. Guest speaker was Jerry Kretchmer, New York City's Environmental Protection administrator.

PERSONALS

First District

John Brewton Rabun of Savannah was named a Fellow of the American College of Radiology in April.

Fifth District

Thomas L. Tidmore, Jr., of Atlanta, was promoted to professor of anesthesiology at the Emory University School of Medicine in March.

Sixth District

Ben Jenkins of Newnan has been appointed executive vice president of Practice Research, Inc., a non-profit corporation which has 93 research projects over the world.

Eighth District

Clyde A. Wilson, Jr., and **Jesse L. Hunt** of Brunswick are leaving private practice in order to assume full-time responsibility for treatment of emergency patients at the Brunswick hospital.

Tenth District

Winford H. Pool of Augusta has been named a Fellow of the American College of Radiology.

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DEATHS

George Felton Hagood, Sr.

Dr. George Felton Hagood, Sr., a Cobb County physician who had been practicing medicine for 65 years, died March 19. He was 95.

Born in Cobb County, Dr. Hagood graduated from Reinhardt College in Waleska in 1899 and from the Georgia College of Elective Medicine and Surgery in Atlanta. He was licensed in 1904, when he began his practice in Cobb County.

A founder of the Cobb County Medical Society, he was its oldest member in both age and tenure. He also had been an active member of the Kennestone Hospital

staff since it was built to replace the old Marietta Hospital—which he helped build.

Dr. Hagood was a member of the Seventh District Medical Society, the Medical Association of Georgia, the American Academy of General Practice, the American Medical Association, the Odd Fellows and Kennesaw Lodge No. 33 F&AM.

He also was a charter member and past president of the Marietta Kiwanis Club, a member of the official board of the Marietta First United Methodist Church, a trustee of Reinhardt College and a former elected member of the Marietta City Council, Board of Education and Board of Lights and Water.

He is survived by a daughter, Mrs. Lola H. Davis, and a son, Dr. Murl M. Hagood, both of Marietta.

MAG MEMBERS ATTEND
14th ANNUAL CONGRESSIONAL LUNCHEON
Washington, D.C.—April 13, 1972



(Left to right, seated): Congressman Fletcher Thompson, Congressman Jack Brinkley, James Kaufmann, M.D., Congressman Phil Landrum, J. Frank Walker, M.D., Congressman John Flynt, Ferrol Sams, M.D., W. C. Mitchell, M.D., Congressman John Davis. (Left to right, standing): Joseph Mulherin, M.D., Mr. James Moffett, Congressman G. Elliott Hagan, John Kirk Train, M.D., Bruce Newsom, M.D., Earnest C. Atkins, M.D., Congressman Ben Blackburn, Charles Andrews, M.D., Congressman Dawson Mathis, Dan Bateman, M.D., Mr. Joe Sports, administrative assistant to Senator David Gambrell, Ollie McGahee, M.D., Congressman Robert Stephens, Donald Branyon, M.D., and Mr. John Dent, legislative assistant to Senator Herman Talmadge.

THE MONTH IN WASHINGTON

The American Medical Association protested again to the federal Price Commission that the Administration's economic stabilization program is discriminatory as it applies to physicians.

A detailed statement outlining the AMA's position was sent to the Price Commission March 27 by Dr. Max H. Parrott, chairman of the AMA Board of Trustees, in response to the commission's announcement in the Federal Register that it was seeking a general review of its policies.

The AMA statement emphasized that the Association supports President Nixon's efforts to curb inflation. But, the AMA said, physicians are "very much concerned that the economic restrictions imposed upon them do not have equal application to all segments of the economy."

Recommends Council

The AMA recommended that the Price Commission establish a Health Industry Council or Committee with representatives of the AMA and other health associations as members.

"Such a committee could provide a direct conduit to the Price Commission of the resources, expertise and experience of its members," the AMA said. Through such a committee the Price Commission would have access to in-depth information accumulated by professional associations in the health care field. Furthermore, a direct channel of communication between the staffs of these organizations and the staff of the Price Commission would provide the Price Commission with assistance not otherwise obtainable.

The AMA expressed confidence that its statement reflected the concern of all physicians regarding the operation of the price control program as it applied to their services. The statement concluded:

"We believe that the comments and suggestions made in this statement reflect the concern of all physicians regarding the present operation of the price control program as it relates to their services. Accordingly, we urge the Price Commission to eliminate the discriminatory rules which single out physicians and other non-institutional providers of health care. We also call upon the Price Commission to foster a simpler, more equitable system for the enforcement of price controls and the processing of applications for exceptions. An application for an exception not processed within 20 days should be deemed to be approved."

Discrimination

The AMA statement pointed out that professional fees, such as lawyers', outside the health profession were not subject to limitations and that "manufacturers, retailers and sellers of services generally are entitled to full pass-through of their increased costs."

The AMA statement continued:

"Of all sellers of commodities and services, only physicians (and other non-institutional providers of health care) are restricted to an aggregate price increase of 2.5 per cent a year in passing through increased costs. We do not believe that this discriminatory restriction is necessary to curb the rate of inflation. If in-

deed such a restriction were needed, the most effective application would be in those segments of the economy which command the bulk of the consumer's dollar—food, clothing and housing.

"The regulations divide health care providers into institutional providers and non-institutional providers for price control purposes. This is an artificial and irrational distinction which should be abolished. The plain fact of the matter is that institutional providers frequently provide all, and always provide some, of the kind of services which non-institutional providers sell. . . .

Eliminate Restrictions

"We are convinced that the special restrictions in the regulations applicable to physicians (and other non-institutional providers) will make no meaningful contribution to the goals of the Price Commission and as a matter of principle should be eliminated. Physicians should be encouraged to invest in new facilities and technology which will elevate the quality of medical care. The 2.5 per cent limitation on the pass-through of additional costs discourages such investments.

"The Economic Stabilization Act requires that the President issue standards to serve as a guide for determining prices, such standards to be generally fair and equitable. The regulations provide for an application for an exception or exemption if the economic stabilization regulations and guidelines will result in serious hardship or gross inequity. However, the regulations do not provide any criteria or standards to be applied when a physician seeks an exception because of 'serious hardship or gross inequity.' We believe that serious hardship or gross inequity is involved where a physician has not increased his fees to keep pace with those charged by his colleagues. Many physicians have held the line on fees despite rising costs. They have delayed raising their fees and in some instances physicians have not increased their fees for several years. We believe that these physicians should not be penalized by being frozen to a substandard level of fees.

Standards for Exceptions

"Standards for exceptions to the price regulations should include provisions for physicians to raise their fees under circumstances such as the following:

"1. Where the price charged for a particular service or services is significantly lower than that most commonly charged in the same community by the same class of providers of health services. Example: A physician specializing in internal medicine whose charge for a routine office visit is significantly less than that most commonly charged by other physicians specializing in internal medicine in the same community.

"2. Where the price charged for a particular service or services is significantly lower than that most commonly charged in similar nearby communities by the same class of providers of health services and the applicant is the only one or one of a few in the same class of providers of health services in the same com-

munity. Example: The only ophthalmologist in a community whose charge for an eye examination for prescription glasses is significantly less than that most commonly charged by ophthalmologists in similar nearby communities.

"3. Where the price charged by the applicant is the price most commonly charged in the community, or less, for a particular service or services and is substantially less than that most commonly charged in nearby communities because of substandard sociological or economic conditions that exist in the applicant's community. Example: A physician practicing medicine in a ghetto area in which the increase in fees during the past four or five years has not kept pace with increases that have generally taken place in nearby communities which have not been subject to such substandard conditions."

Health Legislation

More than 80 members of the House and Senate introduced legislation that would establish a separate Department of Health, a proposal advocated by the American Medical Association for a century.

Chief co-sponsors were a former secretary of Health, Education and Welfare, Sen. Abraham A. Ribicoff (D-Conn.), and the chairmen of two key health subcommittees, Sen. Edward M. Kennedy (D-Mass.) and Rep. Paul G. Rogers (D-Fla.). Twenty-four Democratic senators and 60 representatives, 54 Democrats and 6 Republicans, had signed the bill when it was introduced. Additional sponsors were expected to be added later.

The legislation, which would break up HEW into three departments, ran counter to President Nixon's plan for government reorganization. His plan calls for merger of HEW into a new, even bigger Department of Human Resources. Introduction of the separate health department legislation coincided with Nixon's sending of a second special message to Congress urging action on his reorganization proposal.

Some sponsors of the health department bill indicated they might compromise on two departments—one for health and welfare and one for education.

The AMA House of Delegates in 1873 adopted a resolution calling for a separate federal department "as a means of promoting sanitary science and the protection of the public health." In 1891, the delegates approved appointment of a committee "to memorialize Congress at its next session on the subject of creating a cabinet officer to be known as the medical secretary of public health."

AMA Resolution

Through the years, the House of Delegates has reaffirmed this position, the most recent such action having been in December, 1970, when this resolution was adopted:

"Resolved, That the American Medical Association, in the public interest, continue its efforts to bring about the creation of a separate federal Department of Health, whose chief officer would be a physician of cabinet rank."

"HEW, as presently structured, is unwieldy, unmanageable and therefore unresponsive to both the executive and legislative branches," Ribicoff said in a Senate speech. "No secretary can know what is going on in such a huge department, much less maintain con-

trol of the operation and policy-making apparatus of such a bureaucracy.

"As a former secretary of HEW, I am convinced that health policy can be more rationally developed and the health programs of our nation better handled if they are placed under the jurisdiction of one agency of manageable size, a department of health."

Ribicoff pointed out that HEW, since its establishment in 1953, has "grown into a bureaucracy of 108,000 employees" with an annual budget of nearly \$79 billion, one-third of the entire federal budget. It allocates \$18 billion of the \$25 billion the government spends each year on health programs that are scattered among 23 other agencies as well as HEW, he said.

Ribicoff Proposal

His proposal, if enacted, would transfer all health responsibilities of HEW—including administration of Medicare and Medicaid—to the new department immediately. The President would be authorized to transfer health-care functions of other agencies to the department within 180 days of enactment.

The Ribicoff Bill also would set up a 19-member National Advisory Commission on Health Planning to aid in establishment of the department and to undertake a two-year study leading to recommendations for a 10-year national health policy.

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**118TH
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PROCEEDINGS INDEX

MAG GENERAL SESSIONS

(First Session)

Auxiliary Report	185
SAMA	186
President-Elect's Address	186

(Second Session)

MAG Memorial Service	203
Certificates of Appreciation	203
Fifty Year Awards	204
GaMPAC Awards	204
Distinguished Service Award	204
Future Annual Session Sites	204

(Second Session Reconvened)

Exhibit Attendance Prize	247
Installation of Officers	247
Attendance	248

MAG HOUSE OF DELEGATES

(First Session)

Attendance	186
Credentials Committee	187
Tellers Committee	187
Reference Committees	187
Approval of 1971 Minutes	187
Nominations	187
Councilors and Vice Councilors	188
AMA Delegates and Alternate Delegates	188
FP of the Year Award	189
Annual Reports	189

Unreferred Reports

Vice Speaker	190
Chairman of Council	190
First District Councilor	191
Second District Councilor	191
Third District Councilor	191
Sixth District Councilor	191
Seventh District Councilor	192
Eighth District Councilor	192
Ninth District Councilor	192
Tenth District Councilor	193
Bibb County Medical Society Councilor	193
Cobb County Medical Society Councilor	193
DeKalb County Medical Society Councilor	193
Georgia Medical Society Councilor	194
Richmond County Medical Society Councilor	194
Annual Session Committee	194
Building Expansion Committee	194
Insurance and Economics Committee	195
Medicine and Religion Committee	195
Occupational Health Committee	196
Peer Review Committee	196
Private Practice Committee	196
The Journal	197
Coordinator, Georgia Regional Medical Program	197
Operational Projects of Georgia Regional Medical Program	197

(Second Session)

Attendance	205
Election of Officers	246
Report of Reference Committee A	206
Report of Reference Committee B	212
Report of Reference Committee C	225
Report of Reference Committee D	231
Report of Reference Committee F	240

Reports, Reference Committee Recommendations and Delegates' Actions

Report of Reference Committee A

Physician-Lawyer Liaison Committee	206
Quackery Committee	206
Professional Conduct and Medical Ethics Committee	207
Maternal and Infant Welfare Committee	208
Supplemental Report of Council re Laboratory Services	210

General Business Sessions

First

Second

Second Reconvened

House of Delegates

First Session

Second Session

AMA Delegates	210
Mental Health Committee	211
Resolution 72-8, Commendation of John L. Moore, Jr., and Firm of Alston, Miller and Gaines	211

Report of Reference Committee B

First Vice President	212
Secretary	212
Constitution and Bylaws Committee	215
Liaison Committee with Composite Board of Medical Examiners	219
National Legislation Committee	219
State Legislation Committee	220
Supplemental Report 72-1, State Legislation Committee	222
Resolution 72-1, Change in Qualifications for Membership to the Medical Association of Georgia	222
Supplemental Report 72-3, Retention of Present Councilor Districts	223
Resolution 72-4, Change in Bylaws to Permit Physicians Who Retire at 62 or Are Permanently Disabled to Retain Membership	223
Resolution 72-5, Attorney General's Ruling on Podiatric Practice Privileges	223
Resolution 72-6, Free Choice of Billing Under Medicaid	224
Resolution 72-7, Recovery of Costs Incurred in Fee Collections	224
Resolution 72-9, Legislative Indoctrination Session	224

Report of Reference Committee C

Education Committee	225
Councilors of Medical Association of Atlanta	227
Georgia Medical Care Foundation, Inc.	228
Resolution 72-3, Disassociation of Medical Association of Georgia from Georgia Medical Care Foundation, Inc.	228
Speaker of the House of Delegates	229
President-Elect	229
Supplemental Report 72-2, Allied Health Subcommittee	230
Supplemental Report 72-4, Experimental Medical Care Review Organization (EMCRO)	230

Report of Reference Committee D

President	232
Second Vice President	232
Emergency Medical Services Committee	233
Cancer Committee	235
Communications Committee	237
Rural Health Committee	238
School Child Health Committee	238
Resolution 72-2, Combination of County Society Leadership and New Member Indoctrination Conference with MAG Annual Session	240

Report of Reference Committee F

Woman's Auxiliary to The Medical Association of Georgia	241
Woman's Auxiliary Advisory Committee	242
Treasurer	242
Supplemental Report 72-5, Budget for Fiscal Year 1972-73	243

MAG ANNUAL BANQUET

Certificates of Appreciation	201
Scientific Exhibits Awards	201
Golf Prizes	201
Tennis Prizes	202
Art Exhibit Prizes	202
Medical Mile	202
Civic Endeavor Award	202

MAG General Session (First Session)

118th Annual Session of the Medical Association of Georgia
Friday, May 12, 1972

THE FIRST GENERAL SESSION of the 118th Annual Session of the Medical Association of Georgia was called to order by President W. C. Mitchell, M.D., Smyrna, at 9:00 a.m., in the Ballroom, Macon Hilton Hotel, Macon, Georgia, on May 12, 1972.

Dr. Mitchell welcomed those present, and briefly acknowledged the splendid hospitality being extended by the city of Macon and the Bibb County Medical Society. Dr. Mitchell then called on the Reverend John E. Richards, Pastor of the First Presbyterian Church of Macon, for the invocation.

Dr. Mitchell then asked the assembly to stand for the presentation of the colors by the Central High School ROTC Color Guard. The presentation of the colors was followed by the singing of "God Bless America" by Mrs. John Grenga, accompanied by Mr. Putnam Porter.

President Mitchell then recognized Dr. L. E. Dickey, President of the Bibb County Medical Society, who extended words of welcome to the MAG from the host society. Additional words of greeting were extended by the Honorable Ronnie Thompson, Mayor, city of Macon.

Dr. Mitchell then acknowledged the presence of several distinguished guests and called upon each of them to stand and be recognized. These were: Russell Roth, M.D., Speaker, AMA House of Delegates; Mrs. John Chenault, member of the AMPAC Board of Directors; Mr. Armon B. Neel, Jr., President, Georgia Pharmaceutical Association; and Mr. Roger Lane, Executive Director, Georgia Pharmaceutical Association.

President Mitchell then introduced Mrs. Jean Holmes, who made a slide presentation to the General Session highlighting the places of tourist interest in and around Macon.

President Mitchell next called on Dr. F. G. Eldridge to escort Mrs. George W. Statham of Atlanta, president of the Woman's Auxiliary to the Medical Association of Georgia, to the podium for the purpose of delivering the report of the Auxiliary to the General Session. Mrs. Statham's report highlighted the many activities of the Auxiliary during the past year. Mrs. Statham concluded her remarks by introducing Mrs. G. Prentiss Lee, Portland, Oregon, president of the Woman's Auxiliary to the American Medical Association. Mrs. Lee extended greetings from the Woman's Auxiliary to the AMA.

President Mitchell then announced two special guests who would be extended the privilege of the floor for brief remarks to the General Session. He explained that MAG had followed with keen interest the growth in progress of the two Student AMA



Macon Mayor, the Honorable Ronnie Thompson, welcomes the MAG to his city.

Chapters in Georgia, and was accordingly delighted to extend the privileges of the floor to them. Dr. Mitchell first introduced Mr. Stan Fineman, president of the SAMA Chapter at Emory University. This was followed by an introduction of Mr. Charles Ogburn, president of the SAMA Chapter at the Medical College of Georgia in Augusta. Both Mr. Fineman and Mr. Ogburn delivered brief remarks to the General Session which were well received by the Assembly.

Dr. Mitchell then called on President-Elect F. William Dowda of Atlanta to deliver the address of the Incoming President of the Association. Dr. Dowda responded with an address that outlined many of the programs that he hopes to put into effect during his year as President of the Association. These included: improved internal communications

and more sophisticated and coordinated political-legislative efforts.

President Mitchell thanked Dr. Dowda for his thought-provoking message. He then made several announcements including a reminder that the annual Medical Mile would be run at this year's Annual Session in the Central City Park. He also reminded those present to purchase their annual banquet tickets and their tickets for the first MAG Prayer Breakfast to be held on Sunday morning at 7:00 a.m.

At this point President Mitchell announced that the First MAG General Session would be recessed and that the meeting would be turned over to Dr. Harrison L. Rogers, of Atlanta, Speaker of the MAG House of Delegates, to preside at the First Session of the MAG House of Delegates meeting.

First Session, House of Delegates

Friday, May 12, 1972

THE FIRST SESSION of the House of Delegates to the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., M.D., Atlanta, at 10:10 a.m., in the Ballroom, Macon Hilton Hotel, Macon, Georgia, in conjunction with the 118th Annual Session of the Medical Association of Georgia. The Speaker extended greetings to all of the delegates in attendance and briefly reviewed the schedule for the transactions of business by the House of Delegates during its two sessions—Friday, May 12 and Sunday, May 14, 1972.

Speaker Rogers then called for a report of the delegates in attendance. Dr. J. M. Byne, Jr., of Waynesboro, chairman of the Credentials Committee of the House reported that there were 126 duly elected delegates present representing 46 county medical societies and accordingly announced that a quorum was present.

Attendance

BALDWIN: Samuel M. Goodrich and Pedro L. Tamayo; BARTOW: Richard A. Griffin, III; BEN HILL-IRWIN: Ralph Roberts; BIBB: C. G. Magnan, A. H. S. Weaver, G. C. Schlottman, Charlotte Neuberger, Charles Duggan, J. F. Mendendez and A. M. Phillips, Jr.; OGEECHEE RIVER: Charles R. Richardson; BURKE: J. M. Byne, Jr.; CARROLL-

DOUGLAS-HARALSON: Phil C. Astin and J. Larry Boss; GEORGIA MEDICAL SOCIETY: J. Patrick Evans, J. Robert Logan, F. M. Johnston, William G. Sutlive, F. Debele Maner and John Kirk Train; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, Charles Rey, Steven May, James H. Manning, Gary Palmer, F. Norman Bowles and Luther G. Fortson; COLQUITT: John P. Tucker; COWETA: W. E. Barron; DEKALB: L. C. Buchanan, Knox Walker, Jr., O. Wytch Stubbs, Jr., Robert M. Fine, Roger R. Rowell, William J. Rawls, P. E. Christopher, Timothy Harden, Jr. and Frank E. Morgan, Jr.; DOUGHERTY: J. Daniel Bateman and R. D. Waller; EMANUEL: Robert J. Moye; FLINT: J. T. Christmas; FLOYD-POLK-CHATTOOGA: John F. Atha and James H. Smith; ELBERT-FRANKLIN-HART: McAlpin H. Arnold; MEDICAL ASSOCIATION OF ATLANTA: Robert E. Wells, Hugh S. Thompson, J. Frank Walker, Irving L. Greenberg, L. Newton Turk, III, John S. Atwater, Harrison L. Rogers, Jr., Charles E. Todd, Spencer S. Brewer, Jr., F. William Dowda, Joseph L. Girardeau, Keith Quarterman, Louis Felder, J. Rhodes Haverty, William W. Moore, Armand E. Hendee, Don F. Cathcart, Allan Bleich, Lee R. Shelton, W. Daniel Jordan, Brown W. Dennis, John K. Schellack, James A. Kaufmann, Bob G. Lanier and C. R. Moorhead; GLYNN: William J. Smith, M. A. Glucksman and Benjamin T. Galloway, Jr.; HABERSHAM: Thomas N. Lumsden; HALL: C. W. Whitworth, Billy S. Hardman and

Harvey M. Newman; PEACH BELT: H. E. Weems; JACKSON-BANKS: E. W. Holloway; LAURENS: W. M. Watkins; McDUFFIE: Thomas E. Averitt; MUSCOGEE: Jack Lawler, T. Jack McGee, Jack Hirsch, Bruce C. Newsom, Luther J. Smith and B. Robinson Maughon; OCONEE VALLEY: C. H. Dickens; OCMULGEE: William E. Coleman; RANDOLPH-STEWART-TERRELL: John Bates; RICHMOND: Menard Ihnen, Henry D. Scoggins, J. K. McDonald, Stuart H. Prather, Jr., Cecil A. White, Jr., Ronald F. Galloway, P. D. Ellington, James L. Becton, Luther M. Thomas, Jr., William E. Barfield and George R. Mushet; SOUTH GEORGIA: Charles Hodges and Dewey Barton; SPALDING: James Skinner and Alex P. Jones; STEPHENS: Peter Lampros; TIFT: Mikell B. Karsten; TROUP: H. Hilt Hammett and William B. Fackler; WALKER-CATOOSA-DADE: M. K. Cureton and Ted Cash; UPSON: T. A. Sappington; WALTON: Alexander W. Ashford; WARE: S. William Clark and F. E. Davis; WAYNE: Ollie O. McGahee, Jr.; WHITFIELD: E. T. McGhee and James J. Oosterhoudt; WILKES: M. C. Adair; WORTH: H. G. Davis; SAMA DELEGATES: Stan Fineman, Emory University and Charles Ogburn, Medical College of Georgia.

Dr. Rogers thanked the Chairman of the Committee on Credentials and announced that the business of the House could proceed. He requested that only Delegates sit in the area reserved for MAG Delegates only, since the privilege of the floor was limited to members and ex-officio members of the House of Delegates and that voting must, of necessity, be limited to duly elected Delegates identified by their special Delegates ribbon badges.

Dr. Rogers then introduced the Vice Speaker of the House of Delegates, Dr. Preston D. Ellington, of Augusta. The Speaker then fully explained the methods of consideration of business to be brought before the House of Delegates.

Speaker Rogers then announced the appointment of the House of Delegates' Credentials Committee and the appointment of the House of Delegates' Tellers Committee as follows:

CREDENTIALS COMMITTEE: J. M. Byne, Jr., Waynesboro, Chairman; Luther J. Smith, Columbus and Cecil A. White, Augusta.

TELLERS COMMITTEE: Noah Meadows, Marietta, Chairman; John P. Tucker, Moultrie and Stuart H. Prather, Augusta.

The Speaker then appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: Ralph Roberts, Fitzgerald, Chairman; A. H. S. Weaver, Macon, Vice Chairman; Edwin C. Shepherd, Savannah; Richard L. Benson, Douglas; J. Gary Palmer, Marietta and Spencer S. Brewer, Jr., Atlanta.

REFERENCE COMMITTEE B: L. Newton Turk, Atlanta, Chairman; O. Wytch Stubbs, Jr., Chamblee, Vice Chairman; Richard J. Turner, Clayton; Luther M. Thomas, Jr., Augusta; James H. Smith, Rome and E. W. Holloway, Commerce.

REFERENCE COMMITTEE C: C. W. Whitworth, Gainesville, Chairman; Robert W. Oliver, Jr., Dublin, Vice Chairman; F. M. Johnston, Savannah; B. Robinson Maughon, Columbus; Mikell B. Karsten, Tifton and Robert E. Wells, Atlanta.

REFERENCE COMMITTEE D: W. E. Barron, Newnan, Chairman; Samuel M. Goodrich, Milledgeville, Vice Chairman; Armand E. Hendee, Atlanta; Peter Lampros, Toccoa, C. D. Hollis, Jr., Albany and Jack Lawler, Columbus.

REFERENCE COMMITTEE F: John S. Atwater, Atlanta, Chairman; T. A. Sappington, Thomaston, Vice Chairman; Charlotte Neuberg, Macon; James H. Manning, Marietta and Roger R. Rowell, Decatur.

To expedite the adoption of the minutes of the 1971 Sessions of the House of Delegates held in conjunction with the 117th Annual Session of the Medical Association of Georgia, convened on May 13-15, 1971, at the Marriott Motor Hotel, in Atlanta, the Chair entertained a motion that the minutes, as published in the June, 1971, issue of the *Journal of the Medical Association of Georgia*, be approved. On motion duly made and seconded, it was voted that these minutes be approved as published.

Speaker Rogers then recognized two distinguished guests present: Dr. Russell Roth, Speaker of the AMA House of Delegates and Dr. Thomas B. Goodwin, Augusta, the First Speaker of the MAG House of Delegates.

Nominations

Speaker Rogers then called on the House to proceed with the nominations of officers, AMA Delegates and Alternates and requested that nominating speeches be limited to a maximum of two minutes and seconding speeches be limited to a maximum of one minute each. The Speaker then asked for nominations for the office of MAG President-Elect and the following nomination was made:

PRESIDENT-ELECT: Charles E. Bohler, Brooklet nominated by Leon Curry, Statesboro, Ogeechee River Medical Society; Dr. Bohler's candidacy seconded by F. G. Eldridge, Valdosta, Braswell E. Collins, Macon and John Kirk Train, Savannah.

There being no further nominations for the office of President-Elect on motion duly made and seconded, the nominations were closed.

The Speaker then reminded the Delegates that the Second Vice President automatically accedes to the office of First Vice President, thereby obviating the need to nominate a First Vice President. Speaker Rogers announced that the First Vice President for 1972-73 would be Dr. Braswell E. Collins of Macon.

SECOND VICE PRESIDENT: Virgle W. McEver, Warner Robins, was nominated for the office of MAG Second Vice President by George Green,

Oconee Valley Medical Society; seconded by Charles Todd, Atlanta.

H. Hilt Hammett, LaGrange, was nominated by J. W. Chambers, Troup County Medical Society and seconded by Ronald Galloway, Augusta, and T. A. Sappington, Thomaston.

SECRETARY: Earnest C. Atkins, Decatur, was nominated by L. C. Buchanan, DeKalb County Medical Society, and seconded by Braswell E. Collins, Macon; Stuart Prather, Augusta; Earl McGhee, Dalton; and James A. Kaufmann, Atlanta.

There being no other nominations for the office of MAG Secretary, on motion duly made and seconded, the nominations were closed.

Speaker Rogers announced that the House of Delegates would have an opportunity to vote on Sunday on a constitutional amendment authorizing the election of the Treasurer and in anticipation that the House would adopt such an amendment, he called for nominations for the office of MAG Treasurer. He reminded the members of the House that should they fail to adopt the constitutional amendment on Sunday, he would simply declare nominations for this post to be out of order.

TREASURER: Carson B. Burgstiner, Savannah, was nominated for the office of Treasurer by John Kirk Train, Savannah, and seconded by John S. Atwater, Atlanta; Preston D. Ellington, Augusta; Walter E. Brown, Savannah, T. A. Sappington, Thomaston and J. Frank Walker, Atlanta.

There being no other nominations for the office of Treasurer, on motion duly made and seconded the nominations were closed.

At this point, Vice Speaker Preston D. Ellington was recognized for the purpose of addressing the House. Dr. Ellington offered his resignation as Vice Speaker of the MAG House of Delegates, citing that the press of the many jobs he was attempting to perform for MAG made this move necessary. The Speaker then called for nominations of the office of MAG Vice Speaker and the following were received:

VICE SPEAKER: J. Rhodes Haverty, Atlanta, was nominated by Dr. J. Frank Walker, Atlanta, and seconded by Preston D. Ellington, Augusta.

There being no other nominations for the office of Vice Speaker, on motion duly made and seconded, the nominations were closed.

Speaker Rogers then quoted from Chapter V, Section II, of the Bylaws, which authorize the election of Councilors and Vice Councilors from district societies and component county medical societies. He observed that the following district medical societies and county medical societies had complied with the terms of the Bylaws and had elected the following Councilors and Vice Councilors:

Second District Vice Councilor—Frank R. Miller, Thomasville, 1973 (to fill the unexpired term of Donald J. McKenzie)

Sixth District Councilor—W. E. Barron, Newnan, 1974

Sixth District Vice Councilor—Norman P. Gardner, Thomaston, 1974

Ninth District Councilor—Paul T. Scoggins, Commerce, 1975

Ninth District Vice Councilor—Robert S. Tether, Gainesville, 1975

Tenth District Councilor—Edwin W. Allen, Jr., Milledgeville, 1975

Tenth District Vice Councilor—M. A. Hubert, Athens, 1975

Cobb County Medical Society Councilor—Remer Y. Clark, Jr., Marietta, 1975

Cobb County Medical Society Vice Councilor—Charles R. Underwood, Marietta, 1975

DeKalb County Medical Society Councilor—L. C. Buchanan, Decatur, 1975

DeKalb County Medical Society Vice Councilor—Luther M. Vinton, Jr., Avondale Estates, 1975

Medical Association of Atlanta Councilor—Fleming L. Jolley, Atlanta, 1975

Medical Association of Atlanta Vice Councilor—Thomas J. Anderson, Atlanta, 1975

Richmond County Medical Society Councilor—Ronald F. Galloway, Augusta, 1975

Richmond County Medical Society Vice Councilor—Henry D. Scoggins, Augusta, 1975

AMA Delegates

Speaker Rogers then called for nominations for MAG Delegates to the American Medical Association. He reminded the assembly that all incumbents will serve until December 31, 1972 at which time the new terms of office will begin for the candidates elected at this meeting.

AMA Delegate—for the office held by J. Frank Walker, of Atlanta, the term beginning January 1, 1973 and expiring December 31, 1974—J. Frank Walker, Atlanta, was nominated by Luther H. Wolff, Columbus; seconded by J. Rhodes Haverty, Atlanta.

There being no further nominations on motion duly made and seconded, it was voted to close the nominations.

AMA Delegate—for the office held by Preston D. Ellington, of Augusta with the term beginning January 1, 1973 and expiring December 31, 1974—Preston D. Ellington, Augusta, was nominated by Stuart Prather, Augusta; seconded by R. J. Moye, Swainsboro, Cecil White, Augusta, F. W. Dowda, Atlanta, and Ronald Galloway, Augusta.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Alternate Delegate—for the office held by J. Daniel Bateman, Albany, with the term beginning January 1, 1973 and expiring December 31, 1974

—J. Daniel Bateman, Albany, was nominated by Robert Waller, Albany; seconded by J. Frank Walker, Atlanta, Gordon Davis, Sylvester; and James A. Kaufmann, Atlanta.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Alternate Delegate—for the office held by F. William Dowda, Atlanta, with the term beginning January 1, 1973 and expiring December 31, 1974—F. William Dowda, Atlanta, was nominated by Robert E. Wells, Atlanta; seconded by Braswell E. Collins, Macon; John S. Atwater, Atlanta; Menard Ihnen, Augusta; Ronald F. Galloway, Augusta; Remer Y. Clark, Marietta and David A. Wells, Dalton.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

Speaker Rogers then announced that the elections of officers would take place at the Second Session of the House of Delegates to be convened on Sunday, May 14.

Family Physician of the Year Award

The Speaker recalled an action of the House of Delegates of 1970 which provided that the selection of the recipient of Family Physician of the Year Award would be made by the Georgia Academy of Family Physicians. Accordingly, he called upon Dr. George Mixon, President of the Georgia Academy of Family Physicians, to make the presentation of the Family Physician of the Year Award.

Dr. Mixon stated that the Board of Directors of the Georgia Academy of Family Physicians had selected as its 1972 recipient, Dr. Thomas N. Lumsden of Clarkesville.

Annual Report

Speaker Rogers then called for the Annual Reports of Officers, Council, Councilors, Vice Councilors, AMA Delegates, Association Committees and other reports to be introduced at this Session, which are listed below with the appropriate Reference Committee indicated for those reports which were referred. He observed that the full report, the action of the appropriate Reference Committee indicated and the House of Delegates action on each is listed under the proceedings of the Second Session of the House of Delegates on those reports and resolutions which were referred to Reference Committees. (See pages 206 to 246.)

OFFICERS

- President—Reference Committee D
- President-Elect—Reference Committee C
- First Vice President—Reference Committee B



Dr. Thomas N. Lumsden, recipient of the 1972 Family Physician of the Year Award, is congratulated by Mrs. Lumsden.

- Second Vice President—Reference Committee D
- Secretary—Reference Committee D
- Treasurer—Reference Committee F
- Speaker of the House—Reference Committee C
- Vice Speaker of the House—Not Referred

COUNCILORS AND VICE COUNCILORS

- Chairman of Council—Not Referred
- First District Councilor—Not Referred
- Second District Councilor—Not Referred
- Third District Councilor—Not Referred
- Sixth District Councilor—Not Referred
- Seventh District Councilor—Not Referred
- Eighth District Councilor—Not Referred
- Ninth District Councilor—Not Referred
- Tenth District Councilor—Not Referred
- Bibb County Medical Society Councilor—Not Referred
- Cobb County Medical Society Councilors—Not Referred
- DeKalb County Medical Society Councilor—Not Referred
- Medical Association of Atlanta Councilors—Reference Committee C
- Muscogee County Medical Society Councilor—Not Referred
- Richmond County Medical Society Councilor—Not Referred

ASSOCIATION COMMITTEES

- Annual Session—Not Referred
- Constitution and Bylaws—Reference Committee B
- Finance (1972-73 Budget)—Reference Committee F
- Professional Conduct and Medical Ethics—Reference Committee A
- Emergency Medical Services—Reference Committee D
- Woman's Auxiliary Advisory—Reference Committee F

Building Expansion—Not Referred
 Cancer—Reference Committee D
 Communications—Reference Committee D
 Education—Reference Committee C
 Insurance and Economics—Not Referred
 Legislation (National)—Reference Committee B
 Legislation (State)—Reference Committee B
 Maternal and Infant Welfare—Reference Committee A

Medicine and Religion—Not Referred
 Mental Health—Not Referred (Pursuant to a later action of the House, the report on Mental Health was referred to Reference Committee A)
 Occupational Health—Not Referred
 Peer Review—Not Referred
 Physician-Lawyer Liaison—Reference Committee A
 Private Practice—Reference Committee A
 Quackery—Reference Committee A
 Rural Health—Reference Committee D
 School Child Health—Reference Committee D

SPECIAL REPORTS

Report of the *Journal*—Not Referred
 Woman's Auxiliary to the Medical Association of Georgia—Reference Committee F
 Georgia Regional Medical Program (Coordinator)—Not Referred
 Georgia Regional Medical Program (Director)—Not Referred
 Georgia Medical Care Foundation—Reference Committee C

Speaker Rogers called attention to the reports which were shown above as "Not Referred" and then recognized President W. C. Mitchell for the purpose of making a motion regarding these non-referred reports.

President Mitchell moved that the First Session of the House of Delegates adopt with commendation all reports not specifically referred. Discussion ensued concerning the propriety of adopting reports that had not been reviewed by Reference Committees. Speaker Rogers then recognized Delegate Menard Ihnen, Richmond County Medical Society, who offered a substitute motion that these reports not referred be filed for information at MAG Headquarters and that the report of the AMA Delegation and the Committee on Mental Health be referred to a Reference Committee for further consideration. This substitute motion was adopted and the two reports were referred to Reference Committee A.

The Speaker then announced that all reports not referred to committee would be filed for information. They are as follows:

Vice Speaker

PRESTON D. ELLINGTON, M.D.

I am most appreciative for the opportunity to serve you in the House of Delegates as Vice Speaker.

Your Speaker and I have made many innovations and improvisations which we believe have facilitated

and streamlined the functions of this House of Delegates.

As your Vice Speaker, I have no recommendations at this time.

Chairman of Council

CHARLES E. BOHLER, M.D.

The following is only a brief resume of some of the more important actions taken by Council during the past year. More detailed information can be obtained from the minutes printed in the *Journal*.

The Council maintained its surveillance and supervision of the Georgia Medical Care Foundation during the year and voted at the May 12th meeting to specifically exempt Dr. Rhodes Haverty from the provision in the Foundation Bylaws that trustees must be in the full-time practice of medicine. At the same time, they approved a statement of a Board of Health committee regarding a contract for GMCF processing of Medicaid claims and referred it to the House of Delegates. (The House subsequently approved the Foundation reviewing Medicaid claims for the Board of Health.)

The Georgia Medical Political Action Committee (GaMPAC) is also supervised by the Council and the 19 members of the GaMPAC Board and the Executive Committee of GaMPAC were appointed at the May meeting of Council.

The Council for a long time has been interested in the Headquarters Building expansion program and delegated to the Executive Committee authority to order the feasibility study.

Foremost in Council's considerations has been guidance to the Committee on Constitution and Bylaws. The Council voted to allow the introduction to the House of Delegates language amending the Constitution and Bylaws to provide for an elected Treasurer. This will be accomplished this year. The possibility of changing the name of Council to the Board of Trustees is under consideration and the designation of MAG Past Presidents as honorary members of Council is also being considered. The Committee on Constitution and Bylaws is drafting the necessary changes for House of Delegates consideration.

It was Council that approved the project of mailing cassette taped messages to county medical societies providing this additional means of communication with our members.

As you know, it was Council who first heard of the Governor's reorganization study by having representatives of the Governor's office appear at the September meeting. Council, along with other facets of MAG, has steadfastly held to its original position, supporting the present State Board of Health structure and opposing the separation of the Department of Mental Health from the Department of Health. It was Council that determined that an active public relations campaign should be undertaken by the Legislative Committee to support their position.

In addition to the above matters, Council has expressed itself as the opinion-making, governing body of MAG on many occasions. Among these are: supervision of MAG's financial matters and sometimes necessary authorization of expenditures beyond the approved budget; maintenance supervision over the organization and Bylaws of county medical societies; a review of the laboratory licensing law and recom-

mended amendments; the determination to oppose or support various legislative matters such as physicians' assistants, HMO's and abortions.

Perhaps most significant of Council's recommendations this year should be the vote taken on December 11 to instruct the Committee on Constitution and By-laws to re-submit to the MAG House of Delegates in 1972 language which would allow doctors of osteopathy to become MAG members.

This concludes my third year as Chairman of Council. I wish to take this opportunity to thank the members of Council for their indulgence and patience. The members of Council are most dedicated and conscientious.

I also wish to commend and thank the MAG Headquarters staff for their cooperation and hard work. MAG is most fortunate to have people of their caliber and dedication attending to our affairs.

First District Councilor

CHARLES E. BOHLER, M.D.

As Councilor for the First District, I have attended all meetings of Council during the past year. I have attempted to keep the component Medical Societies of my District acquainted with pertinent Council actions.

The First District Medical Society Meeting will be in April and will be held at the Holiday Inn in Statesboro.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Ogeechee River				
William F. Kent				
Statesboro	19	17	21	19
Burke				
Charles G. Green				
Waynesboro	7	5	7	4
Emanuel				
H. R. Frost				
Swainsboro	6	5	6	5
Laurens				
Grady E. Longino				
Dublin	41	22	40	23
Screven				
William G. Simmons				
Sylvania	5	5	5	5
Southeast Georgia				
Travis Nobles				
Vidalia	18	13	17	11
	96	67	96	67

Second District Councilor

J. DANIEL BATEMAN, M.D.

SECOND DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Colquitt				
R. M. Joiner				
Moultrie	16	13	17	15

Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	17	8	16	8
Dougherty				
L. T. Crimmins				
Albany	61	49	72	59
Mitchell				
A. A. McNeill, Jr.				
Camilla	5	5	5	5
Southwest Georgia				
David Weatherby				
Fort Gaines	12	11	12	9
Thomas-Brooks-Grady				
Thomas F. Lear				
Thomasville	55	47	57	48
Tift				
J. M. Turner				
Tifton	20	16	19	14
Worth				
Robert T. Morgan				
Sylvester	5	5	5	5
	191	154	203	163

Third District Councilor

J. T. CHRISTMAS, M.D.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Flint				
Robert Barr				
Cordele	16	14	15	14
Peach Belt				
B. Lamar Pilcher				
Warner Robins	36	34	40	37
Randolph-Stewart-Terrell				
Earl A. Mayo				
Richland	12	11	11	11
Sumter				
William R. Anderson				
Americus	31	26	30	21
	95	85	96	83

Sixth District Councilor

NORMAN P. GARDNER, M.D.

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Clayton-Fayette				
F. A. Sams, Jr.				
Fayetteville	11	10	12	11
Coweta				
J. J. Thomasson, Jr.				
Newnan	20	14	21	17
Meriwether-Harris				
William Chambliss				
Hamilton	15	13	15	13
Spalding				
William V. Smith				
Griffin	47	44	47	38

Troup				
Steven Byars				
LaGrange	39	33	36	28
Upson				
A. M. Holloway				
Thomaston	19	15	19	15
	<u>151</u>	<u>129</u>	<u>150</u>	<u>122</u>

Seventh District Councilor

DAVID A. WELLS, M.D.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bartow				
Virginia Hamilton				
Marietta	10	6	11	6
Carroll-Douglas-Haralson				
J. E. Parrish				
Carrollton	37	35	40	37
Floyd				
John R. Lovvorn				
Rome	87	76	93	70
Gordon				
Byron Steele				
Fairmount	9	8	10	9
* Polk				
Raymond F. Spanjer				
Cedartown	13	11		
Walker-Catoosa-Dade				
Richard Cureton				
Ft. Oglethorpe	37	24	37	21
Whitfield				
Paul L. Bradley				
Dalton	40	32	51	41
	<u>233</u>	<u>192</u>	<u>242</u>	<u>184</u>

* Polk merged with Floyd

Eighth District Councilor

ROBERT E. PERRY, M.D.

EIGHTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Altamaha				
Chester B. Kanavage				
Baxley	6	6	6	6
Ben Hill-Irwin				
Morgan Smith				
Fitzgerald	8	8	8	8
Coffee				
William R. Wills, Jr.				
Douglas	9	7	9	6
Camden-Charlton				
H. H. Robinson				
Kingsland	9	5	9	5
Glynn				
William F. Austin				
Brunswick	49	43	53	46

Ocmulgee				
William J. Briggs				
Milan	16	14	17	14
South Georgia				
James W. Mathis				
Valdosta	59	45	66	51
Telfair				
D. B. McRae				
McRae	5	4	5	4
Ware				
L. C. Durrence				
Blackshear	41	37	46	41
Wayne				
Ollie O. McGahee, Jr.				
Jesup	13	9	14	8
	<u>215</u>	<u>178</u>	<u>233</u>	<u>189</u>

Ninth District Councilor

PAUL T. SCOGGINS, M.D.

NINTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Barrow				
C. B. Skelton				
Winder	9	8	8	6
Blue Ridge				
H. E. Mitzelfelt				
Blue Ridge	6	5	5	4
Chattahoochee				
Rupert H. Bramblett				
Cumming	21	16	24	19
Cherokee-Pickens				
L. Austin Flint				
Canton	14	14	14	14
Elbert-Franklin-Hart				
Jack Hanks				
Elberton	18	12	17	8



Past Presidents of MAG, Walter E. Brown, M.D. and J. G. McDaniel, M.D., pause to pose.

Habersham				
F. O. Garrison				
Demorest	15	11	10	6
Hall				
Hamil Murray				
Gainesville	64	61	67	62
Jackson-Banks				
S. A. Vickery				
Commerce	9	7	10	7
Rabun				
John T. Crenshaw				
Clayton			5	5
Stephens				
C. D. Gilbert				
Toccoa	23	20	22	19
	179	154	182	150

Tenth District Councilor

EDWIN W. ALLEN, JR., M.D.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Baldwin				
David Cardoso				
Milledgeville	43	33	51	31
Crawford W. Long				
Donald L. Branyon, Jr.				
Athens	72	54	78	59
Jefferson				
James W. Pilcher				
Louisville	5	4	5	4
McDuffie				
Thomas E. Averitt				
Thomson	7	6	7	5
Newton-Rockdale				
L. M. Cowan				
Covington	12	7	12	5
Oconee Valley				
W. H. Rhodes, Jr.				
Union Point	13	11	12	10
Walton				
Robert M. Tankesley				
Monroe	10	9	9	8
Washington				
William Taylor				
Tennille	11	4	10	2
Wilkes				
A. D. Duggan				
Washington	6	5	6	5
	179	133	190	129

Bibb County Medical Society Councilor

BRASWELL E. COLLINS, M.D.

The Bibb County Medical Society had a successful year under the leadership of Dr. Charlotte Neuberg, President. Monthly dinner meetings attained an average of 90 per cent attendance. Twelve new members joined the Society. This increase qualified for an additional delegate to MAG.

One project has been to improve the Physician Image. When a physician participates in a civic or

philanthropic activity, reference is made that he did this as a member of the Bibb County Medical Society. This project of improvement of the physician's image should be a statewide endeavor.

A local Peer Review Committee is being formed within the Society. This committee is to provide a local service and cooperate with the MAG Foundation.

The Bibb County Medical Society looks forward to being host to MAG at the Annual Session in Macon, May 11-14, 1972.

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bibb				
G. Wayne Bohanan				
Macon	183	151	183	155

Cobb County Medical Society Councilor

REMER Y. CLARK, M.D.

Cobb County has continued to expand its medical care both by inpatient care and by an increase of physicians in the county. Our present total Cobb County Medical Society enrollment is 182 members, with 182 Medical Association of Georgia dues paying members, and 171 American Medical Association dues paying members. There have been three membership losses: two by death and one by transfer.

Without reservation, Cobb County is most honored to have had one of its members, Dr. W. C. Mitchell, elected to the office of President of the Medical Association of Georgia. This necessitated the election of Dr. Clark as Councilor and Dr. Underwood as Vice-Councilor. One or both have attended all of the called and regular meetings of Council and have participated in its functions. The Cobb County Medical Society has been active in assisting local and state governmental agencies in planning for future expansion of health care facilities.

This report would not be complete without again giving praise to our Woman's Auxiliary for its efforts with the management of the Kennestone Gift Shop, resulting in the purchase of needed equipment for better patient care and comfort in the hospital.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Cobb				
Donald R. Rooney				
Marietta	168	159	180	169

DeKalb County Medical Society Councilor

M. FREEMAN SIMMONS, M.D.

FOURTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1971	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
DeKalb				
L. L. Freeman				
Chamblee	222	199	228	205

Georgia Medical Society Councilor

L. R. LANIER, JR., M.D.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	Members December 31, 1970	MAG	Members December 31, 1971
		AMA Dues Paying Only		AMA Dues Paying Only
Georgia Medical Society Harry H. McGee, Jr. Savannah	188	172	199	185

Muscogee County Medical Society Councilor

JACK A. RAINES, M.D.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	December 31, 1970	MAG	December 31, 1971
		AMA Dues Paying Only		AMA Dues Paying Only
Muscogee Jack Lawler Columbus	133	112	147	116

Richmond County Medical Society Councilor

J. L. MULHERIN, M.D.

During the past year the Richmond County Medical Society has been represented at every meeting of Council.

The action of the 1971 House of Delegates which increased annual dues from \$40.00 to \$100.00 drew considerable criticism from many of our members with some threatening to resign. Whether many will resign remains to be seen.

The main endeavor of our society in recent months has been our united effort to try to defeat Governor Carter's reorganization plan as far as the Board of Health is concerned. At the present time, however, I wonder how successful our efforts were.

Since this will be my last report as Councilor, I would like to express my appreciation to the officers and staff of the Medical Association of Georgia for their many years of dedicated service.

Dr. Ronald F. Galloway will be the new Councilor, and Dr. Henry D. Scoggins will be Vice-Councilor.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	December 31, 1970	MAG	December 31, 1971
		AMA Dues Paying Only		AMA Dues Paying Only
Richmond J. K. McDonald Augusta	310	271	308	264

Annual Session Committee

PRESTON D. ELLINGTON, M.D., *Chairman*

The Committee on Annual Session of the Medical Association of Georgia again expresses its appreciation to all those members of the Association, the Auxiliary to the Medical Association of Georgia, and to the staff of the Medical Association of Georgia for all their dedicated efforts to make this meeting eventful and informative.

We would especially commend Mr. Edwin Smith and Mrs. Catherine Wooten for their efforts and, of course, to all those other members of the staff and the Local Arrangement Committee members who have assisted us in this effort.

We will continue to plan for you the most informative and educational program that is possible. We would suggest that you urge your colleagues to attend these meetings also.

We appreciate the cooperation that we have received from the Specialty Societies and we note that very few have scheduled their meetings at times other than the MAG Annual Session.

We have no further recommendations at this time.

Building Expansion Committee

F. G. ELDRIDGE, M.D., *Chairman*

Report of the Committee on Building Expansion, in accordance with Supplemental Report 71-6 introduced by Chairman of Council at the 117th Annual Session of the Medical Association of Georgia, June 1971, recommended changes in the MAG Headquarters structure as two possibilities: (1) was to add two additional stories of approximately 24,000 feet, and (2) the other was to add four additional stories of approximately 40,000 square feet and at that time a guaranteed maximum of \$1,089,376.00 was the projected cost of such construction.

This report was approved by the House of Delegates in accordance with the following recommendation: "Council voted to ask the House of Delegates to authorize the Council to proceed with expansion of the Headquarters building based on a favorable feasibility study."

Council then appointed a Building Committee composed of F. G. Eldridge, M.D., Chairman, J. G. McDaniel, M.D., and John S. Atwater, M.D., as members.

The firm of Hammer, Greene, Siler Associates, Economic Consultants, 230 Peachtree Street, N. W., Atlanta, Georgia 30303, were contacted and given the assignment of rendering a feasibility study and report to Council regarding the addition of 40,000 square feet to the present building.

The expense of this feasibility study was estimated to cost some \$3,000.00 and this amount was approved by both Executive Committee and Council. During the course of the feasibility study, the controversy in the City of Atlanta over approval of Metropolitan Atlanta Rapid Transit Authority (MARTA) with a resultant referendum, caused the cessation of the feasibility study until such time as a referendum had been passed and all of the legal entanglements had been eliminated. The feasibility study was completed in February 1972 and contains minute investigative studies of the Peachtree Corridor which extends from downtown Atlanta to approximately 14th Street.

A summation of the report states, "The memorandum indicates that the proposed building expansion is economically feasible in our opinion. Complete objectivity has been maintained throughout this effort and there have been no predetermined conclusions as to development feasibility."

It is anticipated that the entire 40,000 feet will be utilized by Medical Association of Georgia's oriented organizations and that none will be available for rental;

however, even if MAG did not utilize this space, the feasibility study shows that it could be rented producing not only principal and interest payments but would provide cash flow to the Medical Association of Georgia.

Plans are underway to pursue and develop plans and specifications to increase the square footage of the building and the changes which have been outlined in the earlier authorization.

Insurance and Economics Committee

WILLIAM W. MOORE, JR., M.D., *Chairman*

It is a pleasure to submit the following report of the activities of the Committee on Insurance and Economics for the Year 1971-72.

This year has seen the Committee on Insurance and Economics obtain success in several of its on-going projects. The first of these is a commitment on the part of the National Insurance Rating Board to begin to collect data for a re-study of Liability Insurance Risk Categories by specialty. Preparation of this study may take several years, but Georgia has received credit for promoting the idea of re-studying the risk categories by specialty after learning that the present assignment of specialties to a particular risk category were arbitrarily elected by a committee of the American Medical Association working with the National Insurance Rating Board. This selection was made several years ago and based solely on the AMA Liaison's judgment of the exposure of each specialty. After much correspondence and meetings with the Regional Representatives of the National Insurance Rating Board, the Board has committed to begin a concerted effort to determine whether claims experience by specialty will allow a reassignment of risk categories.

Continuous work towards the establishment of a hospitalization and medical plan for MAG members has been carried on this year with the final implementation of a plan yet to be accomplished. Prospects at this writing seem to indicate that a plan will soon be available through the joint efforts of Columbus and Atlanta Blue Shield Plan which will provide a \$50.00 deductible hospitalization plan with a \$600.00 surgical schedule. Blue Shield benefits as well as maternity coverage would be offered as options.

Continued surveillance and review of all of MAG's Group Insurance Plan has been accomplished by the Committee during the year. Significant among this activity has been our liaison with the St. Paul Insurance Company, underwriters of MAG's Group Professional Liability Plan. A major accomplishment of this liaison has been the review of the rate structure applied to the Top Brass Catastrophic Liability Coverage resulting in a reduction in rates, effective January 1, 1972.

The Annual Negotiating Meeting between our Committee and representatives of the home office of the St. Paul Company to review the year's experience under our Group Professional Liability Plan resulted in an increase in the premiums for 1972-73, smaller than those for the previous three years, 17 per cent for Classes II, III, IV and V—with no increase for the 1,400 physicians of Class I.

I wish to express my sincere thanks to those Com-

mittee members who have attended meetings and worked hard in our behalf this year. The thanks of the Committee are also due Mr. Smith and the Headquarters Staff for their assistance. Your Committee hopes that MAG members will bring to our attention any problems they may encounter regarding our insurance benefit package. Your Committee is dedicated to continuing its efforts to provide for the insurance needs of the members through our organization.

Medicine and Religion Committee

W. H. POOL, JR., M.D., *Chairman*

The Medicine and Religion Committee has been active this year as far as many of the individual members are concerned. The primary thrust has been to encourage the activities of various county medical societies as well as other groups in the area of Medicine and Religion. There have been several seminars conducted in the state, probably the more notable being the seminars sponsored by the Cobb County Medical Society, Ministerial Society, Bar Association and Kennesaw Junior College. This is attracting nationwide attention and having a profound influence in the Southeast particularly. This annual seminar is planned again for April of 1972.

An interesting seminar was held in January, 1972, by the Chatham County Medical Society. Dr. John Rabun helped spearhead the activities there. Mr. Bill Hoffman from the AMA, Department of Medicine and Religion; Reverend Fred Reid, Chaplain at North Carolina Memorial Hospital, held programs both with the clergy and with the county society. It is anticipated that this will be the stimulus for continued dialogue between members of the hospital medical staff and chaplaincy staff of two or three of the hospitals in the Savannah area.

The Chairman has had the opportunity to participate in two church organized seminars on Medicine and Religion, one in Augusta, Georgia, and one in Jefferson, Georgia. Mr. Bill Hoffman and the Chairman have also participated in a Pastoral Care Seminar as the chaplaincy program for the Clayton County Hospital is developing. The Chairman attended the Regional Conference of Chairmen of the Medicine and Religion Committees for the Southeast, held in Atlanta. This was again a most stimulating meeting where ideas are shared between the various committees of the Southeast. It is hoped that in the future a weekend retreat may be held with some members of the clergy as well as members of the committees.

The Medicine and Religion Committee is sponsoring a Prayer Breakfast at the annual meeting in Macon on Sunday morning. We plan to discuss the issue "How can we help patients remain WHOLE in a very specialized medical system?" Ray Brewster, from the Religion Department of Mercer University, will be a speaker along with Dr. M. D. Pittard from Toccoa.

The AMA Department of Religion is asking us to undertake a project with representatives from the various seminaries in our state to determine if there is any way the Committee on Medicine and Religion can help them in their curriculum proposals regarding the minister and his part in ministering to the total patient. We plan to accept this responsibility.

Occupational Health Committee

TOM HOWELL, M.D., *Chairman*

The Occupational Health Committee has devoted its energies primarily to the understanding of the Occupational Safety and Health Act and its application to the Industry of Georgia. The Council of the Occupational Health Committee of the American Medical Association was attended and an attempt made to utilize its recommendation in our state program. There is some confusion at this time as to whether the Occupational Safety and Health Department will be under the Department of Labor or under the Department of Workmen's Compensation. When this matter is settled, the Occupational Health Committee will offer its services in appropriate ways.

President Nixon's Committee on Workmen's Compensation met in Atlanta in January, 1972; among other recommendations was the establishment of a program of rehabilitation. The Medical Association is represented on an ad hoc committee attempting to submit initial plans for such a department. Following completion of initial recommendations, the Governor is to appoint a standing committee; present information is that the Medical Association will be represented.

The Occupational Health Committee has no definite recommendations for the House of Delegates.

Peer Review Committee

JOHN R. MCCAIN, M.D., *Chairman*

It is a pleasure to submit this annual report of the MAG Committee on Peer Review for the year 1971-72.

Your Committee has continued its faithful review of all matters brought to it on appeal from the district and local committees on peer review and the Georgia Medical Care Foundation, Inc. Cases considered are retained in confidential minutes made during executive sessions.

In addition to its review activities subcommittees of the Committee on Peer Review have maintained liaison and surveillance over various activities. The subcommittee on Relationships with Third Party Carriers has met during the year with representatives of Prudential Insurance Companies' Medicare Department and assisted in the review by that agency of questions brought by member physicians. Continued liaison with the Regional Office of the Social and Rehabilitation Service of the Social Security Administration has resulted this year in a federal regulation allowing for the payment of claims retained by the Medicare and Medicaid carriers beyond the 24-month limitation when the physician provider was not at fault for the delay.

Of major significance this year has been the work of the subcommittee on Laboratory Proficiency Testing. Arrangements have been made with the College of American Pathologists to have your Committee receive duplicates of the reports sent to physicians on sample tests run in physicians' offices. These duplicate reports are reviewed by the subcommittee on Laboratory Proficiency Testing. The ultimate goal in

this activity is to provide our subcommittee on Education and Discipline with data to support the development of continuing education on appropriate subjects where needed.

While having peer review policy responsibility your Committee considered all requests for policy determination from carriers and physicians. Policy on Payments for such procedures as psychotherapy marathon and jejunostomy were considered with the help of recognized experts. Peer policy has now been assumed by the Executive Committee of Council, and your Committee on Peer Review stands ready to assist them in any way requested.

As Chairman I wish to thank the members of this committee representing the Specialty organizations in Georgia for their dedication and hard work during this year. The Committee wishes to express a most sincere word of appreciation to Mr. Ed Smith and all those who participated on the MAG Staff for their splendid cooperation and assistance given to this Committee.

Private Practice Committee

DONALD R. ROONEY, M.D., *Chairman*

The Committee on Private Practice was combined this year with the Hospital Activities Committee.

The new combined committee first met at the MAG Committee Conclave on August 8, 1971. The fact that the objectives of these two committees are not similar, or sometimes conflicting, was discussed. Committee members decided to retain the name of the Committee on Private Practice and accept any matters referred to the new combined committee.

We co-sponsored two highly successful programs with the Georgia Hospital Association this year. These two programs were designed to acquaint physicians and hospital officials with the new Joint Commission on Accreditation of Hospital standards. Both Seminars were well attended and well received by Medical Association of Georgia members and Georgia Hospital Association members.

This committee considered means of educating our members on the benefits of private practice, and again recommended that a suitable speaker be obtained for the Annual MAG Session. This objective also met with success.

We received, modified and forwarded to Executive Committee a resolution to encourage Departments of Family Practice in area hospitals.

This committee has worked closely with the State Legislative Committee, especially in the study of proposed legislation dealing with private practice or hospitals.

We have established liaison with the AMA Committee on Private Practice and also with the AMA Committee on Health Care for the Poor.

The Chairman of the Private Practice Committee was appointed and is meeting with the Georgia Hospital Advisory Council and hopefully will present the viewpoint of Georgia physicians to this group.

All items referred to this committee during the past year have been promptly acted upon, hopefully to the best interest of the MAG membership.

The Journal

EDGAR WOODY, JR., *Editor*

The 1971-1972 report of the *Journal* of the Medical Association of Georgia is submitted herewith:

PERSONNEL

Since the last annual report we have had no changes in personnel. I am pleased to report, however, that our very efficient managing editor, Miss Pat Thigpen, became Mrs. Rodney Phillips in November. She is continuing at her post with the *Journal* while her husband completes his military service.

I regret to report the passing of one of our most active contributing editors during the past year. Through the years, Dr. Arthur Knight was a faithful contributor to the *Journal* and his contributions will certainly be missed.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

This non-profit bureau in Chicago, devoted to the solicitation and sales of national advertising, sponsored a two-day seminar in New Orleans in September, 1971. These meetings are held every two years and serve to keep state journal editors and managing editors abreast of changes and trends in the field of medical journalism. Workshops are scheduled as part of the program, enabling journal personnel from the various states to exchange ideas in dealing with problems common to all journals. The New Orleans session was both stimulating and instructive.

ADVERTISING

I am happy to report a significant upturn in the national advertising volume in the past 12 months. This has occurred in spite of continuing limitations by the F.D.A. on drug advertising copy. Our sales force working out of the State Medical Journal Advertising Bureau in Chicago are to be commended for their effectiveness.

CONTENT

During the past year an increasing number of papers have been published which have featured discussion concerned with the efficient delivery of health care and with socio-economic problems. In addition to these, we have been fortunate to have submitted many worthwhile scientific papers from the Annual Session and from both medical schools within the state. Clinical conferences from both institutions have been very well received.

CREDITS

During the past 12 months the advice of members of the Publications Committee has been a helpful and decisive force in guiding the course of the *Journal*. Their help is much appreciated. As in the past, our contributing editors have advised and helped in getting suitable scientific material for the *Journal*. Without their assistance, the *Journal* could be little more than a newsletter. During the past year we have had a President who enjoys writing. His pages have been both informative and entertaining and reflect the writer's enthusiasm. Our Legal Page and specialty

pages continue in their tradition of excellence. The editors responsible for these regular features are due much credit. The Headquarters Office Staff continues to play a heavy supporting role in the publication of the *Journal*. Their efforts are much appreciated.

Coordinator, Georgia Regional Medical Program

M. C. ADAIR, M.D.

Having completed nearly two years as Coordinator of the Georgia Regional Medical Program, I find that the concerns of the Program are of vital interest to all of us in organized medicine.

In dealing with heart, cancer, stroke and related diseases, it soon becomes obvious that earlier diagnosis and appropriate treatment are of primary importance. In order to locate and treat cases sooner, few would question the fact that more primary care physicians at health access stations would help accomplish this end. As a matter of fact, the task forces and the Regional Advisory Group have reaffirmed this time and again.

These groups are preponderantly physicians and other health personnel who are living in Georgia and are acquainted with local needs.

Again, it must be stressed that the RAG makes the policies of the GRMP and must have the participation of organized medicine.

The new thrusts into the primary health care field have been suggested by the task forces and Regional Advisory Group. These policies in turn have the backing of the Regional Medical Program Service of the Department of Health, Education, and Welfare.

All programs in Georgia have originated in Georgia and have the approval of the local Group. The GRMP in turn has no desire to enter an area with any program unless it meets with local medical approval.

The GRMP pays its fair share of costs and office expenses in the Medical Association of Georgia headquarters; 25 out of 27 new program applications were approved up to January 1, 1972.

Because of the GRMP's record nationally, a developmental component of funds was allocated to Georgia for new projects and these will not necessarily have to be reported back to the national RMP's.

The Regional Medical Program continues to be active in Inservice Education for medical personnel in hospitals. In turn, more hospitals should avail themselves of this and the visiting consultants.

In conclusion, the GRMP can be a useful tool of medicine in Georgia. More new and innovative programs are needed. GRMP needs physician participation and suggestions. It would also help if we had better attendance of the MAG appointed physicians to the Regional Advisory Group.

Operational Projects of Georgia Regional Medical Program

J. GORDON BARROW, M.D., *Director*

CLINICAL TRAINING CONFERENCES FOR HEALTH PROFESSIONALS

The medical schools at Emory University and the Medical College of Georgia provide specially tailored courses for practicing physicians, nurses, and allied

health workers. Health professionals are given an opportunity to update medical knowledge and skills. Priority is given to health professionals in GRMP area facilities, in turn encouraging further dissemination of the information learned to their peers at the local level.

VISITING CONSULTANTS PROGRAM TO COMMUNITY HOSPITALS

This project continues to serve the community hospitals of Georgia in a variety of ways. Growth in the number of requests for visiting consultants is evidence of the program's success. The project is very flexible and is capable of satisfying specific needs for any segment of the health field.

DETECTION AND ELIMINATION OF ELECTRICAL HAZARDS

To detect and eliminate electrical hazards in hospital electrical systems and in medical electrical monitoring equipment, Dr. Perry Sprawls, Emory University School of Medicine, will conduct five one-day courses for a total of more than 50 attendees. Participants will receive training and handout material which will equip them to initiate training programs in their hospitals as well as to integrate electrical safety into their overall program.

PATIENT AND FAMILY EDUCATION

Northside Hospital (Atlanta), The Memorial Medical Center (Savannah), and The Medical Center (Columbus) have initiated demonstration patient-family education projects. The purpose of the projects is to develop and test a method which can increase—to a significant level—the patient's ability to care for himself, thus eventually permitting a decreased utilization of scarce medical services.

CONTINUING EDUCATION IN NURSING

The purpose of this project is to extend the potential of the School of Nursing, Medical College of Georgia, Program of Continuing Education. With additional instructors, the School of Nursing will take courses into small Georgia communities to provide nurses remote from large medical centers and teaching hospitals an opportunity to benefit from a high caliber continuing education program designed to meet local needs.

SHARED ALLIED HEALTH SERVICES

The past success of the physical therapist feasibility study is leading to the expansion of cooperative multi-institutional utilization of nurses and other allied health professionals. Plans include: nurse anesthetists, clinical nurse specialists, pharmacists, inhalation therapists, speech therapists, physicists, etc.

HEALTH CAREER COUNSELING TO DISADVANTAGED STUDENTS

One hundred predominantly black rural Georgia high school students are participating in a unique health occupations counseling program. GRMP selected 10 high school counselors who then participated in a special orientation in health careers and educational opportunities. Each counselor chose 10 students in their junior year with whom he will work

on a continuing basis throughout the year, offering guidance in selecting a health career. The project calls for group trips to Atlanta to visit practitioners in each of the health areas and, wherever possible, job placement for the students during summer months.

PHYSICIAN ASSISTANT DEVELOPMENT PROGRAM

Emory University, in cooperation with Grady Hospital, continues its Medical Specialty Assistants Program with GRMP support. The Medical College of Georgia is being supported in the planning and development of new programs to train physician assistants.

EDUCATING HEALTH PROFESSIONALS IN OPTIMAL DIABETES CARE

The formation of a Diabetes Day Care Center at Grady Hospital is designed to provide optimal care, education, and follow-up for the 8,000 diabetic patients dependent upon Grady for primary care. Physicians, nurses, and allied health professionals from throughout the region will be taught optimal patient care techniques and methods.

COMMUNITY HEALTH REPRESENTATIVE

Holy Family Hospital, Atlanta, is conducting a demonstration project to improve the health care provided to their patients, through the services of a community health representative who acts as a spokesman, interpreter and advocate for patients and families. In addition to assisting patients in complete utilization of available hospital and community health services, she attempts to assist in the solution of the patient's financial and social problems.

STATEWIDE CANCER PROGRAM

The continued improvement of health care for cancer patients through the provision of optimal treatment and follow-up is the major goal of the statewide system of cancer area facilities which has been established in Georgia. The following institutions are cancer area facilities: Atlanta Medical Center/Georgia Baptist Hospital (Atlanta), Augusta Radiation Therapy Center (Augusta), Crawford W. Long (Atlanta), Floyd Hospital (Rome), Enoch Callaway Cancer Clinic (LaGrange), Medical Center of Central Georgia (Macon), Memorial Medical Center (Savannah), Phoebe Putney Hospital (Albany), St. Joseph's Infirmary (Atlanta), and The Medical Center (Columbus).

In addition to the area facilities, there is a workshop program that provides an opportunity for Georgia physicians to improve the quality of care for their cancer patients and to obtain the latest information: the Georgia Tumor Registry, comprised of 18 hospitals united into a service-oriented statewide tumor registry system; and a component which is developing a cooperative radiation therapy program among facilities in Georgia which provide radiation therapy.

FACILITY PLANNING AND DEVELOPMENT

In conjunction with the above mentioned objectives of the statewide cancer program, this project is planning a major cancer treatment facility in Augusta.

**REGIONAL PEDIATRIC
RESPIRATORY CENTER**

The Medical College of Georgia continues to serve as a regional pediatric pulmonary center demonstrating detailed patient care and providing opportunities for training health personnel in pulmonary disease problems.

COMMUNITY HYPERTENSION PROGRAM

A concentrated effort to detect and control hypertension is being conducted in a predominantly black middle-class urban community of 23,000 adults, age 15 and older, residing in Southwest Atlanta. The program will identify conditions which deter indigent patients from medical care of hypertension and will seek to discover procedures that will encourage indigent patients to seek and accept care.

CARDIOVASCULAR AREA FACILITIES

Cardiovascular area facilities have been established at eight institutions in Georgia, in order to efficiently and effectively provide accessible services for known or potential cardiovascular disease or hypertensive patients. Participating institutions are: Athens General (Athens), Medical Center of Central Georgia (Macon), University Hospital (Augusta), John D. Archbold (Thomasville), Tift General (Tifton), Atlanta Medical Center/Georgia Baptist Hospital (Atlanta), Memorial Medical Center (Savannah), and The Medical Center (Columbus).

**AREA FACILITIES FOR
CONTINUING EDUCATION**

High priority has been placed on continuing education for physicians, nurses, and allied health professionals. Throughout Georgia a group of seven hospitals is coordinating programs to assist smaller hospitals in the development of continuing education programs to satisfy local needs. Hospitals designated by GRMP as continuing education area facilities are: Athens General Hospital (Athens), Kennestone Hospital (Marietta), The Medical Center (Columbus), The Medical Center of Central Georgia (Macon), Memorial Medical Center (Savannah), Phoebe Putney Hospital (Albany), and Tift General (Tifton).

STROKE AREA FACILITIES

Stroke area facilities have been designated at St. Joseph's Infirmary (Atlanta) and Candler General (Savannah), in an effort to expand and extend services for stroke patients through regional cooperative arrangements. The ultimate goal is to have comprehensive services at geographic locations which are accessible to all people in Georgia.

KIDNEY DISEASE PROGRAM

A plan to develop and integrate health care resources for kidney disease throughout the region is being instituted through the joint efforts of Regional Nephrology Centers at Emory University's School of Medicine and the Medical College of Georgia. Plans call for the designation of area facilities at The Medical Center (Columbus) and St. Joseph's Hospital (Augusta) to participate in the kidney program.

**AREA FACILITIES FOR RESPIRATORY
DISEASES**

As one program element through which a comprehensive statewide program to combat respiratory diseases in Georgia, the development of area facilities for respiratory diseases is being supported. Presently, area facilities have been designated at The Medical Center of Central Georgia (Macon), St. Joseph's Infirmary (Atlanta), and Georgia Baptist Hospital (Atlanta).

**EMERGENCY CARE FOR
SOUTH GEORGIA AND NORTH FLORIDA**

This project is designed to demonstrate cooperative arrangements among a multi-county group of hospitals and physicians that will enhance patient care through a network of emergency services with emphasis on the capability for timely response to coronary attacks and highway accidents, utilizing around-the-clock emergency room services and a communications and ambulance system.

**PLAN FOR A STATEWIDE SYSTEM
OF CARE FOR SICK NEWBORNS**

The ultimate goal of this project is to assure that there is an organized system of care designed to meet the individual needs of the newborn that will guarantee an entry into the health care system at the required level of care. Special emphasis will be placed on reducing the hazards of prematurity and providing training to medical and allied health personnel in intensive care techniques for newborns.

**NURSE MIDWIFE SERVICE
IN A MULTICOUNTY AREA**

This project is aimed to demonstrate a mechanism for expanding and improving the maternal health services to a rural, largely indigent population surrounding the Brunswick area, and integrating the services into existing and proposed expanded health care delivery mechanisms.

IMPROVED PRIMARY CARE

Currently funded are three demonstration projects designed to facilitate entry into the health care system in several areas of the state where there has been limited access to services. Specifically, these "health access stations"—staffed by paramedical personnel under physician supervision—are aimed at providing emergency first-aid when needed, providing transportation as required from the station to a doctor's office or hospital, assisting physicians in their assessment of the clinical condition of the patient, and assisting the patient in carrying out instructions of the physician. Demonstration health access stations are located to serve Henry County, Madison County, and Wilcox County. In addition, a planning effort is being supported to develop a health system to improve accessibility to primary care within a four-county area of rural southeast Georgia—Long, Bryan, McIntosh, and Liberty Counties.

Speaker Rogers then proceeded with unfinished business calling for submission of Supplemental Reports from Officers, Councilors and Committee Chairmen.

Supplemental Report 72-1: Committee on Legislation (State)—*Reference Committee B*

Supplemental Report 72-2: Subcommittee on Allied Health—*Reference Committee C*

Supplemental Report 72-3: Council—*Reference Committee B*

Supplemental Report 72-4: Georgia Medical Care Foundation (RE EMCRO)—*Reference Committee C*

Supplemental Report 72-5: Council—*Reference Committee F*

Supplemental Report 72-6: Council—*Reference Committee A*

Speaker Rogers continued with New Business and called for the introduction of Resolutions by the House of Delegates. He requested the resolve portion only of the resolution be read to the House, and the following resolutions were then presented:

Resolution 72-1: Change in Qualifications for membership to Medical Association of Georgia—*Reference Committee B*

Resolution 72-2: MAG Annual County Society and Leadership and New Member Indoctrination Conference with MAG Annual Session—*Reference Committee D*

Resolution 72-3: Disassociation of Medical Association of Georgia from Georgia Medical Care Foundation, Inc.—*Reference Committee C*

Resolution 72-4: Change in Bylaws to Permit Phy-

sicians to Retire at 62 or Permanently Disabled to Retain Membership—*Reference Committee B*

Resolution 72-5: Attorney General's Ruling on Podiatry Practice Privileges—*Reference Committee B*

Resolution 72-6: Free Choice of Billing Under Medicaid—*Reference Committee B*

Resolution 72-7: Recovery of Costs Incurred in Fee Collections—*Reference Committee B*

Resolution 72-8: Commendation of John L. Moore, Jr., and Firm of Alston, Miller and Gaines—*Reference Committee A*

Resolution 72-9: Legislative Indoctrination Session—*Reference Committee B*

Speaker Rogers then called for additional resolutions and none were received.

Speaker Rogers then expressed his appreciation to those members of the House serving on Reference Committees, on the Credentials Committee and the Tellers Committee.

The Speaker announced that the business of the First Session of the House of Delegates had been completed, and that the House would stand adjourned at 12:10 p.m., until the convening of the Second Session of the House on Sunday, May 14, 1972, at 9:00 a.m. Speaker Rogers then turned the gavel over to President W. C. Mitchell to convene the Special General Assembly program.

MAG General Assembly

118th Annual Session of the Medical Association of Georgia Friday, May 12, 1972

THE GENERAL ASSEMBLY of the 118th Annual Session of the Medical Association of Georgia was called to order by President W. C. Mitchell, Smyrna, at 12:10 p.m., in the Ballroom of the Macon Hilton Hotel, Macon, Georgia, on Friday, May 12, 1972.

Dr. Mitchell promised the assembly an interesting program and an outstanding speaker. He reminded them that there are those who would encroach upon the profession and that the Federal government is constantly at their heels these days. He then called upon Dr. Preston D. Ellington to introduce the speaker for the General Assembly.

In introducing Dr. H. E. Godfrey, Dr. Ellington made the following remarks. "Dr. Godfrey took his medical degree at Manchester University, in Man-

chester, England. Subsequently he spent four years in hospital training and served in the merchant navy for one year. In 1957, he took an appointment as an assistant to the health center attached to Manchester University after which he entered general practice. He now spends about half of his working week as the medical officer in charge of the Northern Female Prison establishment. Dr. Godfrey will speak to us on 'Government Controlled Medical Care.'"

Following Dr. Godfrey's presentation, Dr. Mitchell thanked him for coming to be with us, and reminded those present that the afternoon session would begin at 2:00 p.m., and would consist of a panel entitled, "Health Care Delivery Systems, Past, Present and Future." Dr. Mitchell then adjourned the Assembly at 1:05 p.m.

MAG Annual Banquet

118th Annual Session of the Medical Association of Georgia
Saturday, May 13, 1972

THE ANNUAL BANQUET of the 118th Annual Session of the Medical Association of Georgia was held in the Ballroom of the Macon Hilton Hotel, Macon, Georgia, following a reception sponsored by the Bibb County Medical Society, the Georgia Bank and Trust Company of Macon, and the Security Life Insurance Company.

The invocation was offered by Mr. Edwin F. Smith, Executive Director of the Medical Association of Georgia.

Following dinner President Mitchell introduced those sitting at the head table as follows: Mrs. W. C. Mitchell, President-Elect F. William Dowda and Mrs. Dowda; Secretary J. Rhodes Haverty and Mrs. Haverty; Chairman of Council C. Emory Bohler and Mrs. Bohler; Auxiliary President Mrs. George W. Statham and Dr. Statham; AMA Auxiliary President, Mrs. G. Prentiss Lee; MAG Auxiliary President-Elect, Mrs. Cliff Moore, Jr., and Dr. Moore; Bibb County Medical Society Auxiliary President, Mrs. Richard L. Hanberry and Dr. Hanberry; Bibb County Medical Society President, Dr. L. E. Dickey, Jr., and Mrs. Dickey; Bibb County Medical Society Auxiliary Local Arrangements Co-Chairman, Mrs. Ralph G. Newton and Dr. Newton; and Bibb County Medical Society Auxiliary Local

Arrangements Co-Chairman, Mrs. A. H. S. Weaver and Dr. Weaver.

President Mitchell then acknowledged MAG's continuing interest in Georgia's two outstanding medical schools, as he presented to them unrestricted grant monies in the form of AMA-ERF checks raised by contributions from physicians and the Woman's Auxiliary during the preceding year. Dr. Mitchell presented the checks as follows:

To Dr. Curtis Carter, acting dean of the Medical College of Georgia, a check for the Medical College of Georgia in the amount of \$5,341.54.

To Dr. Arthur Richardson, Dean, Emory University School of Medicine, a check in the amount of \$6,530.88.

Certificates of Appreciation

President Mitchell then presented Certificates of Appreciation to Mrs. George W. Statham, President of the Auxiliary to the Medical Association of Georgia for the year 1971-72; to Dr. J. Rhodes Haverty, MAG Secretary, 1966-72; and to Dr. Harry B. O'Rear, as president of the Medical College of Georgia from 1960 to 1972.

Scientific Exhibits Awards

Dr. John N. McClure, Atlanta, chairman of the MAG Committee on Scientific Exhibits, was then called on by President Mitchell to announce the winners in the 1972 Scientific Exhibit as follows:

First Place—"Examination of the Hand"—James L. Becton, M.D. and Joe D. Christian, Jr., M.D., Augusta, Georgia.

Second Place—"Case Vignettes from a Community Hospital"—Department of Pathology, Medical Center of Central Georgia, Macon, Georgia.

Third Place—"Middle Georgia Council on Drugs"—Robert Donner, M.D., president of the council, sponsored by the Bibb County Medical Society, Macon, Georgia.

Golf Prizes

President Mitchell announced that some excellent scores had been carded by those participating in the MAG Golf Tournament and called on Dr.



Mrs. George W. Statham, 1971-72 President, Woman's Auxiliary to MAG.

Richard L. Hanberry to announce the winners. The winners were:

Low Gross—(1) J. L. Mulherin, (2) C. S. Mulherin, (3) Clint Schlottman, (4) Luther Wolff, (5) Frank Eldridge.

Low Calloway Net—(1) Harrison L. Rogers, (2) Fernando Lopez, (3) Roy Denney, (4) Seab Reeves, (5) Charles Richardson, Jr.

Women's Low Calloway Net—Mrs. Lefreda Adair.

Tennis Prizes

Dr. Mitchell then called on Dr. Milton I. Johnson to announce the winners in the Tennis Tournament and make the presentation of prizes as follows:

Men's Singles Winner—Dr. John H. Angell.

Men's Singles Runner-up—Dr. William Moretz.

Women's Singles Winner—Mrs. Gee Homeyer.

Women's Singles Runner-up—Mrs. Anita Ethridge.

Art Exhibit Prizes

President Mitchell then recognized Mrs. Joyce Johnson, substituting for Mrs. Ed Roe Stamps, to announce the winners of the Art Exhibit and make the presentation of prizes as follows:

Painting First Prize—Mrs. Renee Hernandez

Painting Second Prize—Dr. Roy Ward

Painting Third Prize—Mrs. George W. Statham

Painting Honorable Mention—Mrs. J. R. Hutchinson, Mrs. Hugh Gibson

Arts and Crafts—First Prize—Mrs. Martha Ann Poole

Arts and Crafts—Second Prize—Hernando Fernandez (son of Dr. and Mrs. Hernando Fernandez)

Arts and Crafts—Honorable Mention—Dr. Leonard Campbell

Photography—First Prize—Dr. Alex P. Jones

Needle Work—First Prize—Mrs. Paul T. Scoggins

Needle Work—Second Prize—Dr. J. Benham Stewart

Children's Division

First Prize—Connie Dean Meadors (daughter of Dr. and Mrs. Henry D. Meadors)

Second Prize—Alice Washburn (daughter of Dr. and Mrs. Lawrence Washburn)

Third Prize—Pat Sullivan (son of Dr. and Mrs. Daniel B. Sullivan)

Medical Mile

President Mitchell then recognized Dr. W. L. Williams, who announced that Dr. Richard L. Benson, of Douglas, was the 1972 winner of the Medical Mile.

Civic Endeavor Award

President Mitchell reminded the members present that the 1968 House of Delegates had created the Civic Endeavor Award to recognize outstanding public service and participation in civic activities. He stated that this coveted award is presented to the individual selected by the secret committee on awards from nominees submitted by component county medical societies. Dr. Mitchell announced that the 1972 recipient of the civic endeavor award was Dr. William E. Lewis of Macon.

President Mitchell observed that Incoming President F. William Dowda would take the oath of office at the business session the following day. However, he stated that he would like to symbolically pass the torch of leadership to Dr. Dowda at that time, and accordingly requested Dr. Dowda to join him at the podium.

Dr. Dowda expressed his appreciation to Dr. Mitchell, and introduced Mrs. Dowda and quoted briefly from remarks of Dr. Otto Page, Past President of the American Society of Internal Medicine.

Dr. Mitchell then introduced the entertainment for the evening—The Chicago Gaslight Road Show.

SAFE USE OF ETHYL PARATHION

The Georgia Department of Agriculture has entered into an agreement with the U. S. Department of Agriculture to furnish information which will help to insure the safe use of ethyl parathion as an insecticide in the State of Georgia.

Ethyl parathion is an organic phosphate which is being used extensively in the agricultural areas of the state. As is characteristic of the organic phosphates as a group, it is poisonous through ingestion, inhalation and dermal absorption.

The organic phosphates are cholinesterase inhibitors and the symptoms of poisoning are those of parasympathetic stimulation. Symptoms include blurred vision, excessive perspiration, salivation, tightness in the chest, nausea and non-reactive pinpoint pupils.

Atropine is the preferred antidote. 2-PAM is also antidotal and may be used in conjunction with atropine.

MAG General Session

(Second General Business Session)

118th Annual Session of the Medical Association of Georgia
Sunday, May 14, 1972

THE SECOND GENERAL SESSION of the 118th Annual Session of the Medical Association of Georgia was called to order Sunday, May 14, 1972 by President W. C. Mitchell, of Smyrna, at 9:00 a.m., in the Ballroom of the Macon Hilton Hotel, Macon, Georgia.

President Mitchell opened the meeting with the traditional reading of the memorial list of those colleagues who had died since the 1971 Annual Session as follows:

William W. Aiken, Lyons, August 9, 1971
Robert T. Anderson, Dublin, December 1, 1971
J. D. Applewhite, Macon, November 7, 1971
E. T. Arnold, Jr., Hogansville, May 8, 1971
Cecil N. Brannen, Moultrie, November 28, 1971
Glenn J. Bridges, Atlanta, February 26, 1972
Walter H. Bush, Macon, June 6, 1971
Guy L. Calk, Atlanta, November 5, 1971
P. O. Chaudron, Cedartown, December 21, 1971
R. E. Dyer, Atlanta, June 2, 1971
William R. Edwards, Jr., Atlanta, September 1, 1971
Richard F. Graves, Winder, December 11, 1971
J. H. Grubbs, Molena, 1971
Richard Heath, Edison, February 27, 1972
A. C. Hohn, Atlanta, October 21, 1971
Robert E. Huie, Decatur, November 8, 1971
Conway Hunter, Atlanta, September 7, 1971
David F. James, Atlanta, July 26, 1971
A. M. Knight, Jr., Waycross, October 18, 1971
G. H. Lang, Savannah, January 3, 1972
John P. Lindsay, Decatur, January 10, 1972
F. M. Martin, Shellman, November 10, 1971
A. I. Miller, Marietta, July 15, 1971
James F. Olley, Atlanta, February 13, 1972
William K. Philpot, Sr., Augusta, May 8, 1972
Vernon E. Powell, Atlanta, October 4, 1971
George H. Preston, Atlanta, March 6, 1972
Albert A. Rosenberg, Atlanta, December 9, 1971
Scott L. Tarplee, Atlanta, January 4, 1972
Frank H. Thomas, Valdosta, October 18, 1971
Ernest Thompson, Marietta, July 14, 1971
Angvald Vickoren, Forest Park, January 21, 1972
Ernest F. Wahl, Thomasville, October 8, 1971
H. G. Weaver, Macon, December 22, 1971
William O. White, Augusta, September 1, 1971
L. L. Whitley, Athens, December 2, 1971
F. M. Woodall, Thomaston, September 10, 1971

President Mitchell then recognized the Reverend

Frank K. Allen, Rector, St. Paul's Episcopal Church of Macon for the purpose of delivering the invocation and leading the assembly in brief observance of the Sabbath.

Certificates of Appreciation

President Mitchell recognized Secretary J. Rhodes Haverty, M.D. to present MAG Certificates of Appreciation to individuals deserving of special recognition for their contributions to medicine as follows:

W. C. Mitchell, M.D., as MAG President 1971-72; C. E. Bohler, M.D., as Chairman, MAG Council 1969-72; John S. Atwater, M.D., as Treasurer 1962-72; Henry D. Scoggins, M.D., as First Vice President 1971-72; Mr. Ben Porter for Contributions to Legislative Services; Harrison L. Rogers, Jr., M.D. as MAG Chairman of Committee on State Legislation; James A. Kaufmann, M.D., for Outstanding Service to Health Care Legislation; J. L. Mulherin, M.D., as Richmond County Councilor 1969-72; M. Freeman Simmons, M.D., as DeKalb County Councilor 1971-72; Norman P. Gardner, M.D., as Councilor 1970-72; Donald J. McKenzie, M.D., as Vice Councilor 1969-72; Mr. Edwin F. Smith, Executive Director; Beverly W. Forrester, M.D., as Chairman, Board of Health; Earl T. McGhee, M.D., as Vice Chairman, Board of Health; J. T. Mercer, DVM, as Secretary, Board of Health; John Kirk Train, M.D., as Member, Board of Health; W. Frank McKemie, M.D., as Member, Board of Health; James H. Sullivan, M.D., as Member, Board of Health; M. Freeman Simmons, M.D., as Member, Board of Health; Richard H. Smoot, M.D., as Member, Board of Health; Lamar B. Peacock, M.D., as Member, Board of Health; W. A. Dickson, M.D., as Member, Board of Health; P. K. Dixon, M.D., as Member, Board of Health; J. Kenneth McDonald, M.D., as Member, Board of Health; Mr. Harrison Bray, as Member, Board of Health; Mr. LeRoy Claxton, Ph.G., as Member, Board of Health; Mr. John D. Marshall, Ph.G., as Member, Board of Health; Mr. John E. Garner, as Member, Board of Health; A. C. Tuck, D.D.S., as Member, Board of Health; Wesley A. Carr, D.D.S., as Member, Board of Health; Mr. Carl E. Pruitt, as Member, Board of Health.

Dr. Haverty then called upon Dr. Harrison L. Rogers, Jr., of Atlanta, to present four special Certificates of Appreciation as follows:



Dr. John S. Atwater receives a Certificate of Appreciation for his 10 years of service to MAG as Treasurer.

Dr. Rogers presented to Lt. Governor Lester G. Maddox a certificate for outstanding service to health care legislation. Dr. Virgle McEver presented to Senator Stanley E. Smith, Jr., of Perry, a certificate for outstanding service to health care legislation. Dr. Mark Watkins, Dublin, presented to Senator Hugh M. Gillis of Soperton, a certificate for outstanding service to health care legislation. Dr. Ronald F. Galloway, Augusta, presented to Senator R. Eugene Holley, Augusta, a certificate for outstanding service to health care legislation.

President Mitchell recognized Chairman of Council, C. Emory Bohler, who presented Life Membership Certificates in the form of special gold membership cards to MAG Life Members as follows:

H. H. Allen, Decatur; J. Rufus Evans, Stone Mountain; W. R. Garner, Gainesville; Willard R. Golsan, Macon; E. Leonard Graydon, Atlanta; William G. Hamm, Atlanta; J. Fletcher Hanson, Macon; M. A. Hubert, Atlanta; W. O. Martin, Jr., Atlanta; Carl P. Savage, Montezuma; Calvin B. Stewart, Atlanta; J. W. Thurmond, Augusta; and George A. Williams, Atlanta.

Fifty Year Awards

Dr. Henry Scoggins, Augusta, First Vice President, was then recognized for the purpose of presenting Fifty Year Certificates and Pins to members who were graduated from medical school and licensed to practice medicine 50 years ago:

Cecil Brannen, Moultrie; James H. Byram, Atlanta; Charles W. Daniels, Atlanta; James K. Fancher, Atlanta; Frederick D. Funderberg, Monticello; Lewis D. Hoppe, Atlanta; Zachariah W. Jackson, Atlanta; Henry G. Mealing, Augusta; Curtis D. Vinson, Lizella; William C. Warren, Jr., Atlanta; and Richard B. Wilson, Atlanta.

GaMPAC Awards

Dr. Luther M. Vinton, Jr., Avondale Estates, Chairman of the Georgia Medical Political Action Committee, was recognized by President Mitchell for the purpose of awarding engraved plaques for outstanding contributions to the PAC movement in Georgia:

Highest Percentage of GaMPAC Membership in a County Medical Society—Ogeechee River Medical Society

Highest Percentage of GaMPAC Membership in a Congressional District—Fourth District

Largest Total Dollar Contribution to GaMPAC—Medical Association of Atlanta

Distinguished Service Award

President Mitchell then stated that the highest honor that the Medical Association of Georgia could bestow in recognition of service to the Association was the Distinguished Service Award. He explained further that this award is not necessarily given annually, but is awarded only when a selection committee deems a member to be especially deserving. Dr. Mitchell then announced that the 1972 recipient of the Distinguished Service Award was Dr. Edwin W. Allen, Sr., of Milledgeville. Dr. Allen received a standing ovation as he came forward to receive the award.

Future Annual Session Sites

President Mitchell then recognized Dr. Preston D. Ellington, Chairman of the MAG Committee on Annual Session, for an announcement of future meeting sites.

Dr. Ellington announced that invitations had been received from local medical societies through 1980 and they are as follows:

1973—Augusta

1974—Savannah

1975—Atlanta

1976—Jekyll Island

1977—Macon

1978—Augusta

1979—Savannah

1980—Atlanta

At this point President Mitchell announced that the Second General Session was now recessed and turned the gavel over to Speaker Rogers to convene the Second Session of the MAG House of Delegates.

Second Session, House of Delegates

Sunday, May 14, 1972

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia held in conjunction with the 118th Annual Session of the Association was called to order by Speaker Harrison L. Rogers, Jr., M.D., of Atlanta, at 10:05 a.m., in the Ballroom, Macon Hilton Hotel, Macon, Georgia.

The Speaker recognized Delegate Robert E. Wells, Atlanta, for the purpose of making a request for support from the doctors of Georgia for the Sickie Cell Foundation.

Speaker Rogers called for the report on attendance and Dr. Cecil White of Augusta reporting for the Committee on Credentials reported that over 40 delegates were present and accounted for, that a quorum was present and therefore the House could proceed with the business. The Speaker declared a quorum present and the House of Delegates duly in session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

Attendance

In a compilation of attendance taken from the official roll, 43 county medical societies were represented by their duly elected Delegates or Alternates. In total, 134 Delegates were present at the Second Session. They were as follows:

BALDWIN: E. W. Allen, Jr.; BARTOW: Richard A. Griffin, III; BEN HILL-IRWIN: Ralph Roberts; BIBB: C. G. Magnan, A. H. S. Weaver, G. C. Schlottman, F. V. Kay, Charlotte Neuberg, Charles Duggan, J. F. Menendez and A. M. Phillips, Jr.; OGEECHIE RIVER: Charles R. Richardson; CARROLL-DOUGLAS-HARALSON: Phil C. Astin and J. Larry Boss; GEORGIA MEDICAL SOCIETY: J. Patrick Evans, J. Robert Logan, F. M. Johnston, John Kirk Train, William G. Sutlive and F. Debele Maner; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, Charles Rey, Donald R. Rooney, Steve May, James H. Manning, Gary Palmer, F. Norman Bowles and Luther G. Fortson; COLQUITT: John P. Tucker; COWETA: W. E. Barron; DEKALB: L. C. Buchanan, Knox Walker, Jr., O. Wytch Stubbs, Robert M. Fine, Roger R. Rowell, William J. Rawls, P. E. Christopher, Timothy Harden, Jr. and Frank E. Morgan, Jr.; DOUGHERTY: J. Daniel Bateman, C. D. Hollis and R. D. Waller; EMANUEL: Robert J. Moye; FLINT: J. T. Christmas; FLOYD-POLK-CHATTOOGA: John F. Atha and James H. Smith; MEDICAL ASSOCIATION OF

ATLANTA: Robert E. Wells, Hugh S. Thompson, J. Frank Walker, Joseph S. Wilson, Fleming L. Jolley, Irving L. Greenberg, L. Newton Turk, III, Paul Counce, Edwin Pound, John S. Atwater, Harrison L. Rogers, Jr., Charles E. Todd, William D. Logan, Spencer S. Brewer, Jr., J. Harold Harrison, F. William Dowda, Joseph L. Girardeau, Keith Quarterman, Louis Felder, J. Rhodes Haverty, Frank L. Wilson, William W. Moore, S. A. Shmerling, Thomas J. Anderson, William E. Huger, Armand E. Hendee, Don F. Cathcart, Allan Bleich, Nicholas E. Davies, W. Daniel Jordan, Brown W. Dennis, John K. Schellack, James A. Kaufmann, Bob G. Lanier and C. R. Moorehead; GLYNN: William J. Smith, M. A. Glucksman and Benjamin T. Galloway, Jr.; HABERSHAM: Thomas N. Lumsden; HALL: C. W. Whitworth, Billy S. Hardman and Harvey M. Newman; PEACH BELT: H. E. Weems and Virgle W. McEver; JACKSON-BANKS: E. W. Holloway; LAURENS: W. M. Watkins and Robert Oliver; MUSCOGEE: Jack Lawler, Bruce C. Newsom, Luther J. Smith, B. Robinson Maughon and J. H. Sullivan; OCONEE VALLEY: George F. Green; OCMULGEE: William E. Coleman; RANDOLPH-STEWART-TERRELL: John Bates; RICHMOND: Menard Ihnen, Henry D. Scoggins, J. K. McDonald, J. L. Mulherin, Stuart H. Prather, Jr., Cecil A. White, Jr., Ronald F. Galloway, Preston D. Ellington, James L. Becton, Luther M. Thomas, Jr., William E. Barfield and George R. Mushet; SOUTH GEORGIA: Charles Hodges and Dewey Barton; SPALDING: James Skinner and Alex P. Jones; STEPHENS: Peter Lampros; THOMAS-BROOKS-GRADY: Frank R. Miller; TIFT: Mikell B. Karsten; TROUP: H. Hilt Hammett; WALKER-CATOOSA-DADE: M. K. Cureton and Ted Cash; UPSON: T. A. Sappington; WARE: S. William Clark and F. E. Davis; WAYNE: Ollie O. McGahee; WHITFIELD: E. R. McGhee and James J. Oosterhoudt; WILKES: M. C. Adair.

Speaker Rogers then reminded the Delegates that election of the Treasurer was conditioned upon acceptance by the House of a Report by the Committee on Constitution and Bylaws which authorizes election of the Treasurer. By consent this portion of the Constitution and Bylaws Report was put to the House. With a voice vote taken, the House approved election of the Treasurer as a voting officer of Council and the Executive Committee of Council.

Speaker Rogers then recognized Dr. J. Rhodes Haverty for the purpose of making an announcement. Dr. Haverty stated that the MAG Legal Counsel had advised that nominations from the floor could not be made at the Second Session of the House of Delegates unless nominees from previous Sessions

withdrew. Accordingly in an effort to make possible further nominations for the office of Vice Speaker from the floor of the House of Delegates, Dr. Haverty announced his withdrawal as a nominee for the office of Vice Speaker.

Speaker Rogers then announced that the floor was open for nominations for the office of MAG Vice Speaker. Delegate Menard Ihnen nominated Dr. J. Rhodes Haverty for the office of Vice Speaker. There were numerous seconds from the floor not identified.

Dr. F. G. Eldridge, Valdosta, nominated Dr. Joe Stubbs for MAG Vice Speaker. Dr. Stubbs' nomination was seconded by Dr. Dan Jordan of Atlanta, and many other delegates from the floor unidentified.

On motion duly made and seconded, it was voted that the nominations be closed.

At this point, Delegate M. C. Adair moved the affirmative election of all uncontested nominees to the positions for which they were nominated at the First Session of the House of Delegates. By a voice vote, this action was approved, and the Speaker declared those uncontested nominees to be duly elected.

Speaker Rogers suggested use of the white ballot in the Delegates Handbook for the purpose of voting in the election for MAG Vice Speaker as the printed ballot contained no provision for an election to this office.

Speaker Rogers then read the names of the nominees in contested races and they were as follows:

Second Vice President—H. Hilt Hammett, *LaGrange* and Virgle W. McEver, Jr., *Warner Robins*

Vice Speaker—J. Rhodes Haverty, *Atlanta* and Joe C. Stubbs, *Valdosta*

At this point balloting was conducted by the Tellers Committee

Reference Committee Reports

Speaker Rogers then called for reports from the Reference Committee Chairmen. He explained that the matter of business as introduced was to be considered as a motion on the floor and that if no discussion or dissent followed each portion of the Reference Committee Report, he would rule the item adopted as introduced. However, in the event that a Reference Committee amended a report or presented a substitute, the House should consider it the motion before the House. The Speaker explained that the Chair would rule each item adopted pending final vote on the entire report of each Reference Committee.

Report of Reference Committee A

Ralph Roberts, M.D., *Chairman*

Chairman Roberts reported to the House that reports and resolutions referred to Reference Committee A had been considered by the Committee which met at 9:00 a.m., in the Jasmine Room, Macon Hilton Hotel, Macon, Georgia, on May 13, 1972. Members of the Committee present included: Ralph Roberts, M.D., Fitzgerald, Chairman; A. H. S. Weaver, M.D., Macon, Vice Chairman; Richard L. Benson, M.D., Douglas, J. Gary Palmer, M.D., Marietta and Spencer S. Brewer, Jr., M.D., Atlanta.

Physician-Lawyer Liaison Committee

J. FRANK WALKER, M.D., *Chairman*

The Joint Medico-Legal Committee of the Medical Association of Georgia and the State Bar of Georgia has continued to be relatively active during this past year in its attempts to mediate and/or arbitrate disputes arising between individual physicians and attorneys. At this time, during the past year, much of the activity has been by mail or by telephone.

I wish to congratulate your Co-chairman, Attorney Ogden Doremus, of Savannah, for his talents and abilities in such activities, particularly when lawyers complain.

Your Joint Committee continues to utilize the "Principles Governing Physician-Attorney Relationships" as approved and adopted by the Medical Association of Georgia and the State Bar in 1969.

RECOMMENDATIONS

(1) The need to exert continued efforts to stimulate the formation of additional Joint Medico-Legal Committees at county society levels.

(2) The need to continue to urge the development of additional presentations by or under the direction of the Joint Medico-Legal Committee to local bar associations and/or county medical societies.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of Recommendation (1) and (2); with the additional recommendation that the establishment of a medical-legal panel to arbitrate professional liability suits be referred to the Committee on Physician-Lawyer Liaison for study.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Physician-Lawyer Liaison with the additional recommendation recommended by the Reference Committee.

Quackery Committee

JAMES A. KAUFMANN, M.D., *Chairman*

The Committee on Quackery continued its efforts to alert the profession and make it aware of the real dangers inherent in chiropractic. Programs on Chiropractic were put on before the 6th, 7th, 9th and 10th District Medical Societies—society meetings to which all members of the General Assembly from the District were invited along with the physician members of the District Society.

In its continuing effort to expose the true cultist nature of Chiropractic the Committee distributed books, pamphlets, reprints from the *Reader's Digest* and other pertinent data.

At the September meeting of the Committee it was assumed that 1972 would be the year in which MAG would take the offensive in its attempt to stem the growing menace of Chiropractic. Considerable background work and key contact work preceded this meeting. The probability that MAG would proceed with positive legislation addressed to the matter of Chiropractic was encouraging. Shortly thereafter it was learned that the Executive Reorganization Plan contemplated the abolition of the Board of Health and the merger of the Department of Health into a new super agency, Human Resources.

MAG Council determined that defense of the Board of Health would be the number one legislative priority for 1972. With virtually 100 per cent of our time and attention directed toward the Human Resources proposal we were unable to give adequate attention to the Chiropractic matter.

With practically all of our attention given to the Human Resources proposal the Chiropractors were able to take the offensive and made far better progress with their bill than ever before. The bill sponsored by the Chiropractors is one they called the "Insurance Equality" Bill. Actually it was a compulsory bill that would have forced all health and accident insurance policies to be written (or re-written) to provide coverage for Chiropractic services. There exists no similar law to require an insurance company to pay for physician services.

This bill (S. B. 474) introduced by Senator Pete McDuffie of Eastman, passed the Senate 31 to 9. In the House it was favorably reported from the Committee on Insurance and was temporarily stalled in the House Rules Committee. On the last day of the '72 Session the Rules Committee voted 11 to 5 in favor of keeping the bill off the calendar, thus making it impossible to be called up for a vote. This took place at approximately 10:30 a.m. Less than 10 hours later the Rules Committee reversed itself and voted to put the bill on the calendar. The action of the Rules Committee was in obvious response to the pressure exerted by the Chiropractors and their legislative allies on the last night of the Session. Throughout the final day there were more than 100 Chiropractors roaming the halls of the Capitol "lobbying" in behalf of their bill.

The bill was ultimately called up for a vote and failed to pass by a very slim two votes. (All bills must receive 98 votes—only two short of the required number.) There were only 43 votes cast in opposition to this bill.

The closeness of the vote will undoubtedly inspire and encourage the Chiropractors to come back again next year and have another go at it. This year will be an election year—all seats in the General Assembly are up for election—and votes for or against the Chiropractic bill will (and should) be garnered by the basket load this summer and fall.

The two vote spread was the closest MAG has ever come to losing on a Chiropractic bill. In the past we have succeeded in defeating such bills in the first Committee to which they have been assigned. We have never had a floor vote on Chiropractic in the memory of anyone presently associated with legislative

activities. The reason we had one this year is simple: With our attention fully given to Human Resources we simply lacked the time in which to adequately inform the members of the General Assembly as to the real dangers in voting for a bill of the type sponsored by the Chiropractors. This House of Delegates has the assurance of the Committee that this will not happen again.

Chiropractic remains the overriding quackery problem in Georgia. Effectively controlling Chiropractic remains the number one objective of our Committee on Quackery.

RECOMMENDATIONS

Your Committee recommends that the Committee on Quackery be continued and that it continue to lead the entire medical profession in efforts to combat the spread of Chiropractic; and that at the appropriate time legislation to curb the activities of Chiropractors be sponsored with aggressive support from all sectors of the profession.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Quackery.

Professional Conduct and Medical Ethics Committee

T. A. SAPPINGTON, M.D., *Chairman*

There have been two meetings of the committee during the past year. The first at the Committee Conclave and the second at the request of the MAG Council to study requests of Podiatrists requesting appointment to hospital staffs in Augusta. The committee recommended to Council that Podiatrists not be granted staff privileges in hospitals in Georgia.

All complaints concerning Medical Ethics and Professional Conduct received by the committee have been referred to the local medical society for their action. A quarterly report of complaints received by the committee is sent to each member of the committee. This has been of great value as each of the committee is being kept informed of all complaints received.

At the request of Council, the Chairman of this committee met with Dr. Louis O. J. Manganiello, Chairman of the State Board of Medical Examiners, in Augusta, to discuss the possibility of establishing a State Medical Disciplinary Board. MAG legal staff has been requested to draft such legislation to be studied by this committee and the State Board of Medical Examiners so that a proper and satisfactory bill can be decided on and then to present it to the State Legislature after such a bill has been approved by both the State Board of Medical Examiners and the Medical Association of Georgia.

There still seems to be a conflict in the Constitution and Bylaws of the Medical Association of Atlanta and the Constitution and Bylaws of the Medical Association of Georgia as to who should assume responsibility of primary investigation of complaints concerning Professional Conduct and Medical Ethics.

RECOMMENDATION

I feel that the Constitution and Bylaws of the

Medical Association of Atlanta should be changed so as to not be in conflict with the Constitution and By-laws of the Mother Organization—The Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval with the deletion of the words “Mother Organization” in line 5 on Page 2 of the report, so that the recommendation would read: “I feel that the Constitution and Bylaws of the Medical Association of Atlanta should be changed so as to not be in conflict with the Constitution and Bylaws of the Medical Association of Georgia.”

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Professional Conduct and Medical Ethics.

Maternal and Infant Welfare Committee

EUGENE L. GRIFFIN, M.D., *Chairman*

Under the chairmanship of Dr. Eugene Griffin this Committee continued in 1971 to study in detail each maternal death from information obtained. It also concerned itself with other matters pertaining to maternal and infant health in the State of Georgia. Major areas of activity are listed below.

LIVEBIRTHS AND BIRTH RATE

There were 95,584 livebirths in 1970. The birth rate increased to 20.7 (19.4 in 1969). This increase in birth rate was due to an increase of the white live-birth rate from 17.8 in 1969 to 19.3 in 1970. The non-white livebirth rate increased in the past year from 24.1 in 1969 to 24.8 in 1970. (Preliminary data indicate that there were approximately 95,000 livebirths in 1971.) Hospital deliveries reached a high of 96.9 per cent compared to a rate of 95.8 per cent in 1969.

MIDWIFE ACTIVITIES

There were 2,492 (2.6 per cent) livebirths attended by midwives in 1970. This represented a decrease of 687 or 21.6 per cent less than the previous year. In 1970, more than 8,000 hospital deliveries were paid for under Medicaid (Title XIX).

MATERNAL MORTALITIES

There were 36 maternal deaths in Georgia in 1970 out of a total of 95,584 livebirths. The death rate of 3.8 per 10,000 livebirths represented an increase from the 3.2 rate of 1969. The leading causes were abortion (6) and toxemia (6). Also of significance were pulmonary embolus (3); ectopic (3); and hemorrhage (3).

IMMATURE BIRTHS

In 1970 there were 8,688 immature livebirths (313 more than in 1969) for a rate of 90.9 per 1,000 livebirths (decrease from 92.9 in 1969). Immaturity at birth is twice as frequent in the nonwhite as in the white race. It is also significant that immaturity occurs more frequently in livebirths to the mother under 18 in both races.

Per Cent of Immature Livebirths—1968-1970

	1968	1969	1970
White	7.3	7.0	7.1
Nonwhite	13.8	14.1	13.4
White Under 18	10.9	9.9	10.0
White 18 to 39	6.9	6.8	6.9
Nonwhite Under 18	17.3	16.3	16.0
Nonwhite 18 to 39	13.2	13.7	12.9

BIRTHS TO UNWED MOTHERS

There were 11,029 livebirths to unwed mothers, an increase of 848 over the previous year. The rate rose from 112.9 to 115.4 between 1969 and 1970. Livebirths to white unwed mothers (2,418) increased 272, and livebirths to unwed nonwhite mothers (8,611) increased 576 from the previous year. Immaturity at birth is significantly influenced by marital status both generally and racially.

Per Cent of Immature Livebirths—1968-1970

	1968	1969	1970
Married	8.8	8.6	8.3
Unmarried	14.2	14.4	14.5
White Married	7.1	6.8	7.0
White Unmarried	11.1	11.4	10.3
Nonwhite Married	13.1	13.6	11.2
Nonwhite Unmarried	15.0	15.2	15.6

LIVEBIRTHS TO GRAND MULTIPARA

A total of 5,107 livebirths (5.4 per cent) in 1970 were in the order of sixth and over, compared to 5,661 livebirths (6.3 per cent) in 1969. Since 1960 the per cent of *first* and *second* births to a mother has been increasing in both races. However, the per cent of births in the order of *third* or *greater* have shown significant declines. In 1960, 41.3 per cent of all white births were in the order of third and greater. In 1970 this had declined to 28.0 per cent. The percentage of third and greater order livebirths among the nonwhite has declined from 60.6 per cent in 1960 to 39.0 per cent in 1970.

ADOLESCENT PREGNANCIES

Livebirths to adolescents representing 19.6 per cent of all livebirths in 1960 have increased to 23.4 per cent of all livebirths in 1970. There were 9,063 livebirths to mothers under 18 years of age out of the total of 22,331 adolescent livebirths. Of the livebirths to unwed mothers 54.3 per cent were to adolescents. One out of every eight infants liveborn to an adolescent is immature by weight at birth.

NUTRITION

All counties have some supplemental type of food program for pregnant mothers. One hundred and thirteen have Food Stamp Programs and 46 have the Surplus Commodity Program. Because of the number of different state and federal agencies involved in the food programs there is a great discrepancy of service to the consumer between various counties in the state.

PERINATAL MORBIDITY AND MORTALITY

Because of the recommendations of the committee and the Medical Association of Georgia relating to medical information to be obtained with the birth certificate, the Department of Public Health has studied methods of obtaining confidential medical data and adopted a new Certificate of Livebirth which will meet the needs for vital registration as well as medical biostatistical analysis. A tentative target date of July, 1972, has been set for the new certificate.

THERAPEUTIC ABORTION

According to records received by the Georgia Department of Public Health, there were 1,754 therapeutic abortions performed in Georgia in 1971. This was a rate of approximately 20 per 1,000 livebirths estimated for the year. The following are reports for the years 1968 through 1971:

FAMILY PLANNING

As of December 31, 1971, there were 48,000 women actively participating in the State Health Department Family Planning Program (1970—36,000). This number is based upon proven continuous active contraceptors by current records in the State data collection computerized evaluation system. The number is on

the conservative side, as it does not include a large number of women who received services before the institution of the current record system and who may well be continuing as active contraceptors. During the calendar year 1971 there were 37,500 admissions to service and a total of 106,000 follow-up visits provided through Health Department clinics. The greatest deterrent to more rapid expansion of this program has been the lack of sufficient physician time for services.

CERVICAL CANCER SCREENING PROGRAM

During fiscal year 1971 the Statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Public Health provided Pap smears to indigent and medically indigent patients receiving health service from local health departments for over 38,000 women. Since the beginning of the program in 1967, approximately 108,000 Pap smears have been done, and a diagnosis of malignancy has been made in 275 cases. Eighty-five per cent of the malignancies were preinvasive carcinoma of the cervix (235), and only 15 per cent (40) were invasive carcinoma of the cervix. Treatment of diagnosed cases has been provided by state assisted tumor clinics and by private physicians.

STATE ABORTION REPORTING SUMMARY FOR GEORGIA, 1968 TO 1971

Year End Totals					Year End Totals				
1968 1969 1970 1971					1968 1969 1970 1971				
1. Number of abortions ...	73	168	701	1,579	b. 1	1	34	98	253
2. Number of live births ..	87,322	90,195	95,584	95,322	c. 2	20	23	113	273
3. Deaths related to legal abortion					d. 3	11	15	111	212
4. Number of deaths secondary to non-hospital abortions					e. 4	8	7	46	99
5. Race					f. 5 or more	5	8	33	100
a. White	69	147	567	1,036	g. Unknown	2	0	1	5
b. Black	3	21	133	538	10. Residency				
c. Spanish-American ...	1	0	1	5	a. In-state	73	168	701	1,579
d. Other	0	0	0	0	b. Out-of-state				
e. Unknown					11. Reasons, if applicable				
6. Age					a. Maternal physical health	16	23	59	217
a. Less than 15	4	85	32	64	b. Maternal mental health	30	103	521	484
b. 15-19	5	42	172	418	c. Fetal deformity	24	29	36	34
c. 20-24	12	41	160	429	d. Rape or incest	3	9	12	10
d. 25-29	25	36	151	258	e. Contraceptive failure ..	0	1	9	71
e. 30-34	11	24	88	201	f. Social or economic hardship	0	0	58	743
f. 35-39	11	11	67	140	g. Other	0	3	6	20
g. 40-44	4	8	28	64	h. Unknown	0	0	0	0
h. More than 45	0	1	3	5	12. Abortion procedure				
i. Unknown	1	0	0	0	a. Suction D & C	8	2	127	400
7. Weeks of gestation (from 1st day of last menstrual period)					b. Surgical D & C	26	85	279	553
a. 8 or less	24	41	201	467	c. Saline induction	6	12	95	234
b. 9-12	27	68	326	713	d. Prostaglandins	0	0	0	0
c. 13-16	13	26	73	162	e. Hysterotomy	7	14	27	33
d. 17-20	6	17	82	224	f. Hysterectomy	7	9	48	99
e. 21-24	1	3	16	8	g. Other	1	0	6	4
f. 25 or more	0	1	1	4	h. Unknown	18	46	109	256
g. Unknown	2	12	2	1	13. Number of women who had sterilization procedure at same hospitalization	13	12	76	131
8. Marital status					14. Number of hospitals performing at least one abortion procedure	18	23	34	38
a. Single	21	86	393	831	15. Number of counties with at least one abortion procedure	14	17	26	28
b. Married	52	74	308	571	16. Number of physicians performing at least one abortion procedure	60	97	167	199
c. Separated	0	2	7	89					
d. Divorced	0	6	25	77					
e. Widowed	0	0	0	9					
f. Unknown	0	0	0	2					
9. Number of living children									
a. 0	20	81	299	646					

MEDICAID

As a result of MAG recommendations, the State Medicaid (Title XIX) program has authorized payment for sterilizations and therapeutic abortions for eligible patients.

RECOMMENDATIONS

(1) That the Medical Association of Georgia urge its members to participate more fully in the statewide Family Planning Program by making available more physician hours of service to indigent and medically indigent persons.

(2) That the Medical Association of Georgia use every means available to encourage public and private health institutions to cover the full cost of health services relating to prenatal care, delivery, postpartum care, pediatric care for the first year of life, contraceptions, sterilizations and the proper termination of unwanted pregnancies.

(3) That the Medical Association of Georgia foster the concept of a stable state population until such time that poverty, disease, inadequate medical care and inadequate housing no longer remain prevalent in the State.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of Recommendation (1); approval of Recommendation (2) with changes so that it would now read: "That the Medical Association of Georgia use every means to educate the public of the existing availability of prenatal care, delivery, postpartum care, pediatric care and family planning (contraceptives, sterilizations and proper termination of unwanted pregnancies)"; and approval of Recommendation (3) with changes so that it would now read: "That the Medical Association of Georgia foster the concept of a zero rate population growth."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Maternal and Infant Welfare with the amendment recommended by the Reference Committee.

Supplemental Report of Council re Laboratory Services

C. E. BOHLER, M.D., *Chairman of Council*

The present utilization of private and state operated clinical laboratories was reviewed by Council in its meeting May 10.



Luther Vinton, M.D., dispenses good will at the AMPAC-GAMPAC booth.

RECOMMENDATION

It is the recommendation of the Council that the House of Delegates establish as the policy of MAG that members be encouraged to utilize private facilities for their diagnostic laboratory work.

REFERENCE COMMITTEE ACTION—No action was taken by the Reference Committee as the source of information was not available.

HOUSE OF DELEGATES ACTION—Filed for information.

AMA Delegates

J. W. CHAMBERS, M.D., *LaGrange*

Mr. Speaker, and members of the House of Delegates:

As Chairman of your A.M.A. delegation, I am happy to report both the Annual session in Atlantic City and the Clinical session in New Orleans, La., to have been well attended by your entire delegation. Both of these sessions of the House of Delegates of the A.M.A. continue to be quite busy sessions, requiring the full attention of your entire delegation at each session.

One of the most discussed, and perhaps controversial topics of the Annual Session was the introduction by President Hall in his address of a call for a constitutional convention in order to reorganize the A.M.A., as he expressed it, for the purpose of streamlining the governing process of the A.M.A. to suit the pace and needs of the Twentieth Century physician and people. The House voted to refer the matter of the constitutional convention to the Council on Constitution and Bylaws and to the Council on Long Range Planning and Development to prepare position papers on the pros and cons of the subject of a constitutional convention and report back to the House at the Clinical session in New Orleans, La.

At the Clinical session in New Orleans, after an adequate report from these two Councils, the House of Delegates voted to have two open sessions during the 1972 conventions to explore the questions relating to A.M.A. organizational structure and programs, and the questions raised by President Wesley Hall at Atlantic City and again in New Orleans. This subject will of course be discussed at the forthcoming annual session in San Francisco in June.

Also introduced in the House at Atlantic City, and subsequently acted upon in the Clinical session at New Orleans, was the possibility of the establishment of a special section for medical students and for interns and residents. This was approved in New Orleans to establish the creation of a special section for medical students, and a section for interns and residents. Also, it was approved that a direct membership for interns and residents could be established in those states which had difficulties in interns and residents being able to join the A.M.A. through the normal course of the constituent society memberships. Your Georgia delegation spoke against the direct memberships circumventing the constituent association since we in Georgia have no prohibiting regulations which would require direct memberships, but we did not prevail in our discussion.

One additional piece of legislation which was adopted by the House of Delegates at the Clinical session in New Orleans was the approval of voting privileges on

the Board of Trustees for the Vice-President, which had been advocated previously by your delegation but was not approved at that time, but at the Clinical session in New Orleans this was approved. This action increases the size of the Board of Trustees from 15 to 16 voting members. This, however, will not become effective until a constitutional change can be brought up and passed by the Council on Constitution and Bylaws at the Annual meeting in June of this year.

There was also considerable discussion relating to the rapidly developing field of physician assistants. The delegates adopted a report of the Council on Medical Education outlining essential requirements for A.M.A. approval of educational programs for physicians' assistants. These were developed in collaboration with the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Society of Internal Medicine. I believe this House would be interested in knowing that Dr. Milton Helpern, the Chief Medical Examiner for the city of New York, who was guest speaker at our last session of the Medical Association of Georgia last year, was chosen to receive the A.M.A. Distinguished Service Award for 1972, and this will be presented to Dr. Helpern in San Francisco in June.

One other final discussion on the matter of Peer Review was brought up and passed by the House reaffirming the A.M.A.'s attitude towards Peer Review being carried out only by physicians who are Peers of those doing the Review. Two resolutions were adopted in this particular area during the session.

Most of you, I am sure, know that J. Frank Walker, M.D., former speaker of this House of Delegates, is a candidate for the speaker of the A.M.A. House of Delegates, and up until the present time is unopposed, and of course has the full support of the Georgia delegation. I would urge that you write any of your friends over the country whom you think might have influence in this regard.

Your delegation still continues to function, I believe, efficiently, and attempts to represent you to the best of its ability in the A.M.A. House of Delegates. I regret to inform this House of the retirement of Carter Smith, M.D., at the Clinical session in New Orleans as a member of the A.M.A. House of Delegates from the section on Internal Medicine, and also, as you recall, the retirement of Neil Yeomans, as of the Clinical session in New Orleans as an alternate delegate from the Medical Association of Georgia.

Again I would urge all members of the House of Delegates of the Medical Association of Georgia to more actively participate in the affairs of the A.M.A., and to attempt to carry the message of the importance of the entire echelon of organized medicine and its importance to every physician in the United States. Various members of your delegation will be available for questions from any members of the House that they might wish to pose for us.

Thank you, Mr. Speaker.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee accepted this report with commendation to the delegates for their outstanding work.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA Delegates with commendation.

Mental Health Committee

A. S. YOICHEM, M.D., *Chairman*

Specific and reasonable changes were adopted for the residential study of the Georgia Association for Retarded Children. To the Governor's study on alcohol it was emphasized that the medical problem involved expanding programs to a more statewide area and keeping it under the Board of Health.

The Committee supported the Governor's Commission on Emergency Medical Services and endorsed the restriction of Amphetamine and Methamphetamine prescriptions.

After considerable debate it was urged to retain the State Board of Health but with the Director of the Division of Mental Health to have more autonomy and direct access to the appropriate legislative bodies. It stood opposed to the Governor's Reorganizational Plan as pertaining to physician and mental matters of our state.

Support was given to certain legislative matters pertaining to modification of the Georgia Health Code.

This committee sincerely appreciates and thanks the MAG Council and its various committees for their increasing cooperation in the field of Mental Health.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends continued support for the Georgia Association of Retarded Children.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Mental Health and recommended continued support for the Georgia Association of Retarded Children.

Resolution 72-8

Commendation of John L. Moore, Jr., and Firm of Alston, Miller and Gaines

ROBERT E. WELLS, M.D.

WHEREAS, the law firm of Alston, Miller and Gaines has represented the Medical Association of Georgia as special counsel from 1956 thru 1958 and has represented the Association as general counsel from January 1, 1959 to April 20, 1972, and

WHEREAS, the members of this law firm, particularly partner John L. Moore, Jr., have rendered outstanding legal assistance to the medical profession in Georgia during all these years above and beyond what might normally have been expected of them,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates does hereby thank and commend John L. Moore, Jr. and the firm of Alston, Miller and Gaines for outstanding legal service to the medical profession in Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends that this Resolution be filed.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee on Resolution 72-8.

Chairman Roberts then expressed his appreciation to the members of the Reference Committee for their time and efforts, and moved that the reference committee report be adopted as a whole. This motion was duly seconded and approved.

Report of Reference Committee B

L. Newton Turk, M.D., *Chairman*

Chairman Turk reported to the House of Delegates that the reports and resolutions referred to Reference Committee B had been considered by the Committee which met at 9:00 a.m., in the Wisteria Room, Macon Hilton Hotel, Macon, Georgia, on May 13, 1972. Members of the Committee present included: L. Newton Turk, M.D., Atlanta, Chairman; O. Wytch Stubbs, Jr., M.D., Chamblee, Vice Chairman; Luther M. Thomas, Jr., M.D., Augusta, James H. Smith, M.D., Rome and E. W. Holloway, Jr., Commerce.

First Vice President

HENRY D. SCOGGINS, M.D.

This concludes my second year as a member of the Executive Committee of Council, and I wish to express my sincere appreciation to the House of Delegates and the members of the Medical Association of Georgia for giving me the honor of serving as your Second and then First Vice-President of a great Medical Association.

Again, I wish to express my appreciation to the Administrative Staff for their efficiency and cooperation during the past year.

RECOMMENDATIONS

(1) That the Executive Committee of Council appoint a committee and request that the Georgia Bar Association appoint a similar committee whose duty would be to form an arbitration panel for malpractice litigations. This panel's job would be to set up statewide guidelines that could be used on a local level.

(2) That the Constitution and Bylaws be amended so that there will be more M.D. representation on the Executive Committee of Council. I would suggest four: (1) to represent the southern section of Georgia; (2) the middle section of Georgia; (3) the northern section of Georgia; and (4) the greater Atlanta area. These physicians would be nominated by their respective sections and voted on by the House of Delegates at the Annual Sessions for staggering terms to be determined by the Constitution and Bylaws Committee.

(3) That the DE-5 classification for Doctors from the Medical Association of Georgia be reduced to age 65 so as to be in more accordance with other retirement plans including social security.

(4) That the Second Vice-President of the Medical Association of Georgia be made a voting member of Council.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of recommendation 1 as amended. When amended recommendation 1 would read, "that the Executive Committee of Council appoint a committee and request that the Georgia Bar Association appoint a similar committee whose duty would be to investigate the feasibility of forming an arbitration panel for malpractice litigations."

On recommendation 2, it is recommended acceptance for information, but that the matter be referred to the Long Range Planning Committee for study and further recommendations. The reference committee observes that there is no organization set up for a division of the State into sections from which additional Executive Committee members would be selected.

On recommendation 3, the reference committee recommends disapproval. The committee feels that adoption of this recommendation would artificially discourage participation in the affairs of the Association and further that non-dues paying members with full voting rights should be held to the current level.

At this point a typographical omission was acknowledged in that the reference committee report failed to show the position of the reference committee with respect to recommendation 4 of the report of the First Vice President. Chairman Turk, referring to his rough draft notes made at the time the reference committee was in session, advised that the reference committee recommended disapproval of recommendation 4.

HOUSE OF DELEGATES ACTION—Adopted the amended report of the First Vice President as recommended by the reference committee.

Secretary

J. RHODES HAVERTY, M.D.

The Medical Association of Georgia has had another banner year. Our association is a true leader and continues to increase, both in quality and in quantity, regarding membership, and in programmatic involvement related to the health of the people of Georgia.

1971 MEMBERSHIP REPORT

The membership of the Medical Association of Georgia has grown by approximately 4 per cent in the past year, or for a total of 138 members increase. Incidentally, this is reflected by an increase in the number of our delegates in this House by 10. A breakdown of the categories of membership for the calendar year 1971 is as follows:

1971 MEMBERSHIP SUMMARY

Active	3,373
DE-1	39
DE-2	55
DE-3	53
DE-4	17
Life	170
Associate	76
Service	59
Honorary	1
Affiliate	1
Student	2
	3,846

GEORGIA REGIONAL MEDICAL PROGRAM

There will be a separate report by the MAG Coordinator of the Georgia Regional Medical Program included in this annual issue of the Proceedings. However, since a notation concerning the program as it relates to the Officers of the Medical Association of Georgia has appeared yearly in the Secretary's Column, mention will be made at this point also.

There has been a turn-around in national funding for the Regional Medical Program during this past year, and there is continued recognition by the federal government of Georgia's leadership in this field, under the capable direction of Dr. J. Gordon Barrow, Director of the Program. This continued recognition has been reflected by sizeable increases in funding in our state, increases significantly greater than the large majority of other regions (states).

Your President and Secretary, in their weekly meeting at the headquarters office, have the opportunity to discuss with Dr. Barrow and he with us, all aspects of the Georgia Regional Medical Program. Thus, we may anticipate problems before they arise and the liaison keeps the leadership of the Medical Association and the staff of the Regional Medical Program knowledgeable about the activities and thoughts of each.

Dr. Charles Adair of Washington, Georgia, continues to look after the best interests of the Medical Association in the programs of the Georgia Regional Medical Program, and we are all fortunate to have such a dedicated, hardworking physician to represent us as Coordinator.

MAG FOUNDATION

The MAG Foundation also continues to expand. The bank balance as of 12/31/70 was \$4,377.54, as opposed to the balance on 12/31/71 of \$7,303.50.

The House of Delegates at its last meeting directed the Council to budget \$1 per member to the MAG Foundation for the purpose of building up an account to pay indigent physicians and physicians' widows a monthly stipend. This first budgeting will take place in May, just prior to this Annual Session, 1972. This sum is not reflected in the above bank balance, which obviously, will grow to something over \$11,000 by the time this House meets.

It is interesting to note that in my first report as Secretary of the MAG, I noted the formation of this Foundation, and in this, my last report to the House as Secretary, I can reassure you that this Foundation is serving some needs previously not served and consolidating others into a single instrument for charitable and educational pursuits. The Foundation is well established and will continue to grow in size and in importance to our state.

The present Trustees for the year 1972 are as follows, with the expiration dates of their terms of office following their names:

J. Frank Walker, M.D., President—December, 1974
J. Rhodes Haverty, M.D., Vice-President—December, 1972

John T. Mauldin, M.D.—December, 1973

Mr. Everett Williams—December, 1975

Mr. Edwin F. Smith—ex-officio, December, 1976

Charles R. Andrews, Jr., M.D.—December, 1977

CHAMPUS PROGRAM

The MAG Champus program continues to be exemplary of the better programs of this type in the nation. The Department of Defense, as well as the physicians and patients paid through this program, are well satisfied with the method of handling claims which the MAG supervises. One problem of delayed payments occurred during this past year, particularly during the summer and early fall months, but steps

have been taken to correct this problem, and additional personnel hired, and the time lag is now back to within acceptable limits.

The following chart is a summary of services for the year 1971, as compared with the previous year, 1970. Briefly summarized, it is evident that total claims received continue to rise year by year; total claims paid, and total dollar amounts continue to rise as well. Also, the average amount paid per claim continues to rise.

One item of explanation might be given. It is evident that the number of claims rejected has increased precipitously in 1971 over 1970. This relates to the reimbursements to patients, primarily for outpatients' visits and for drug use, both of which classes of claims have increased dramatically as well. The primary reason for the rejects in these instances is that the patient had not as of the time of submission of the claim built up the total of \$50 deductible necessary before the payment of any such claims. These rejects do not represent to any great degree payment of physicians' claims.

HEADQUARTERS OFFICE

In 1968 I recommended that we enlarge the MAG headquarters office, only eight years after moving into our new building. I implied further expansion would be needed before the end of the '70's. It is interesting to note now only four years after the last enlargement (which came eight years after a move because of lack of space), we are presently engaged in further expansion. This will be dealt with in other reports, but I merely wish to add my own support for this move. It has been wisely conceived and planned to this point under the capable leadership of Dr. Tex Eldridge, and can be financed sensibly without an increase in dues or a special assessment, and will be sorely needed by the time it is built. Incidentally, at this rate, it would seem that in two more years we would have to enlarge again!

Our headquarters office staff continues to expand, along with everything else it seems, and presently totals 91 employees of the Medical Association of Georgia. Forty-two of these employees work for the GRMP; 13 for CHAMPUS, 18 for Medicaid and the Foundation, and 18 specifically for the MAG and its related activities. It should be noted here that one of new MAG employees is Mr. Wallie Carpenter, presently headquartered in Macon, who is our field representative for the southern half of our state. Wallie and Carl Bailey are doing a fine job in keeping constant communications going between the county societies and the headquarters office and the officers of the MAG.

It should be noted with nostalgia, real affection, and some sadness, that Miss Thelma Franklin is ending her full-time employment with the MAG by retirement this year. I am quite certain that there is no one individual alive in the MAG that can recount in its entirety the truly selfless devotion to the MAG by Thelma Franklin. Each of us has his own memories of this great lady, ones which he will cherish, and ones which he hopes that Thelma, herself, will cherish while she is away from us. We wish her well, of course, but we will miss her sorely. God bless you, Dear.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
STATISTICAL REPORT

Claims	Annual		% Total		Average per month		Average per day*		1971 vs 1970 % + or -
	1970	1971	1970	1971	1970	1971	1970	1971	
Received—Total	51,596	57,295	100	100	4,300	4,775	201	227	11+
Inpatient ¹	30,965	29,514	60	52	2,580	2,460	121	117	4-
Outpatient	15,965	22,248	31	39	1,330	1,854	62	88	39+
Drugs ²	4,722	5,533	9	9	394	461	18	22	17+
Returned	7,688	7,154	15	12	641	596	30	28	7-
Rejected	3,336	5,307	6	9	278	442	13	21	59+
Review Committee	24	61			2	5			
Paid—Total	\$41,505	\$46,729	80	82	\$3,459	\$3,894	162	185	12+
Regular (inpt. + outpt.)	37,142	41,019	72		3,095	3,418	145	162	
Handicap	1,001	1,060	2	79	84	88	4	4	
Drugs	3,362	4,650	6	84	280	388	13	19	
Total Dollar Amount Paid	\$4,258,075.06	\$4,846,746.34	100	100	\$354,839.59		\$403,895.53		14+
Regular	3,797,488.78	4,281,675.14	88	88.4	316,457.40		356,806.26		
Handicap	349,898.78	408,232.12	9	8.4	29,158.23		34,019.34		
Drugs	110,687.50	156,839.08	3	3.2	9,223.96		13,069.92		
Average paid per claim									
Regular	\$102.25	\$104.38							
Handicap	349.54	385.12							
Drugs	32.92	33.73							

Note:

¹ Includes Handicap Program claims.² Includes consolidated reimbursement and vendor payments.

* 1970 = 256 days

1971 = 253 days

Mr. L. B. Storey will be assuming the position vacated by Miss Franklin and has been on the headquarters staff of the Association since the first of the year, becoming more familiar with our procedure. We are looking forward to a long association with L. B. and are happy to have been able to woo him away from the Medical Association of Atlanta, where he held a similar position.

The House of Delegates saw fit last year to adopt my suggestion of having an elected office of Treasurer of the MAG. I am grateful for this and feel that the MAG will benefit by this move. This office, as an elected one, can be a powerful office in the Association, and should be viewed as such. I trust it will be a contested election each time it is held, and that men of the strongest caliber will aspire to this office.

May I remind this House that its distinguished past speaker, Dr. J. Frank Walker, will be running for that same office of Speaker in the AMA House of Delegates next month in San Francisco. We are proud of Frank, both his past performances and contributions to us in our own state, as well as to his present and future contributions at the national level. Of course, we wish him well and Godspeed.

Before I make my recommendations, may I be indulged for a moment of personal reflection? These past six years serving as your Secretary, and the activities surrounding this office, have been some of the most satisfying in my entire life. I look back to that day when Dr. J. G. McDaniel called and asked me if I would consider running for the position, and my anxiety about that decision. I look back at the trials and tribulations, the work and the successes, incident to this job with a glow of pleasure and pride. I count the friendships that I have made in the MAG through

this position as an incalculable joy. I will leave this position with true sadness, and a void will be created which cannot be filled in the future in any way.

After any such tenure as one this long, the changes brought about by new people are inevitable, and will be very noticeable. Your new Secretary will have new ways of doing things; some of them will be better, some not so well as his predecessor, but they will be different. His first year will be difficult, but I am sure he can count on your support and encouragement just as I have for these past six years. Thank you all.

RECOMMENDATIONS

(1) I leave as a last recommendation for this House to consider suggestions concerning the composition of the House itself. As I noted near the beginning of this report, the House has been increased by 10 members this year. This process of gradual increase seems likely to continue for the foreseeable future, as the MAG continues to grow. There will be 176 delegates to the Annual Session this year. With one of the suggestions that will be made below, this could be increased to 200 members. This truly begins to get unwieldy. My suggestion is that a Study Committee of the House be appointed by the Speaker, in conjunction with the Constitution and Bylaws Committee Chairman to draw up a plan of re-allocating delegates to this House. I would expect this ad hoc committee to bring back to this House for consideration its proposals by 1973. Since any such proposal could involve changes in the Constitution, as well as the Bylaws, it is not likely that changes would become effective prior to the Annual Session of 1974, but by then it is quite possible that we will have a House of 220 members.

(2) An additional recommendation would be to direct this ad hoc committee to include in its recommendations back to this House the inclusion of one delegate elected from each specialty society represented by a state society chapter in Georgia.

Again, I thank you for the privilege of serving as Secretary of this great Association.

REFERENCE COMMITTEE RECOMMENDATION
—Your committee accepts the report of the Secretary with commendations and acknowledgement of the clarity and completeness of this report.

Regarding recommendation 1 the reference committee recommends disapproval with the additional recommendation that the matter be referred to the Committee on Long Range Planning.

On recommendation 2, the committee recommends disapproval on the basis that representation by specialty societies in the MAG House of Delegates appears to be unnecessary as they are adequately represented through the general membership.

HOUSE OF DELEGATES ACTION—Delegate Robert E. Wells, of Atlanta, moved to amend the report of the reference committee by deletion of the phrase “disapproval of the additional recommendation” so that the reference committee report regarding recommendation 1 of the Secretary would then read, “regarding recommendation 1 the reference committee recommends that the matter be referred to the Committee on Long Range Planning.” The House then voted to approve the report of the reference committee as amended.

Constitution and Bylaws Committee

JOHN T. MAULDIN, M.D., *Chairman*

ITEM 1: TREASURER

Action taken by the 1971 House of Delegates:

It was the will of the House that the Treasurer be an elected Officer of MAG and a voting member of the Executive Committee and Council for a three year term. The Chairman of the Finance Committee is to be continued to be appointed by the Chairman of Council. The House determined that their action satisfied the first reading as a constitutional amendment and directed the Constitution and Bylaws Committee to prepare exact language to accomplish that purpose. The House further directed that this matter be published in the *Journal* of MAG and directed that the requirements of Article XIII of the Constitution and Bylaws be satisfied.

A. Amendments to the Constitution

1. Amend Article V., Section 1, of the Constitution by deleting from the third line of the present Section 1 the word “Treasurer.” Section 1 of Article V. as amended will then read as follows:

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component county medical societies as provided in the Bylaws. The officers, the Past Presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

2. Amend Article VI., Section 1, by inserting in the third line thereof between the word “Secretary” and the

word “Speaker” the word “Treasurer.” Also delete the words “the Treasurer” in line 4.

Section 1 of Article VI. as amended will then read as follows:

SECTION 1. COMPOSITION. Council is composed of the President, the President-Elect, the Immediate Past President, the two preceding Immediate Past Presidents, two Vice-Presidents, Secretary, Treasurer, Speaker of the House of Delegates and Councilors as provided by the Bylaws. Delegates to the AMA, the Editor of the *Journal* and the Executive Director shall be ex-officio members of Council without the right to vote. Vice-Councilors shall be ex-officio members except in the absence of their respective Councilors as provided for in the Bylaws. The Vice-Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

3. Amend Article IX., Section 1, by inserting in the second line thereof between the word “Secretary” and the word “the,” the words “the Treasurer.”

Section 1 of Article IX. as amended will then read as follows:

SECTION 1. DESIGNATION. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Councilors and Vice-Councilors as provided for in the Bylaws.

4. Amend Article IX., Section 4, by inserting in the second line thereof between the word “Secretary” and the word “Speaker” the words “the Treasurer.”

Section 4 of Article IX. as amended will then read as follows:

SECTION 4. TERMS OF OTHER OFFICERS. Other officers shall be elected for terms of one year each except the Secretary, the Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates and the Councilors and Vice-Councilors, who shall serve for three years. One-third of the Councilors and Vice-Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

B. Amendments to the Bylaws

1. Amend Chapter IV., Section 1, first paragraph, of the Bylaws by inserting in line 3 thereof between the word “Secretary” and the word “Speaker” the word “Treasurer.” The first paragraph of Section 1 of Chapter IV. as amended will then read as follows:

SECTION 1. COMPOSITION. The Council is composed of the President, the President-Elect, the Immediate Past President who shall serve as a full member of Council for a period of 3 years, two Vice-Presidents, Secretary, Treasurer, Speaker of the House of Delegates or Vice-Speaker of the House of Delegates and Councilors or Vice-Councilors selected as follows:

2. Amend Chapter IV. Section 1, last paragraph, by deleting from the next to last line of said paragraph the words “the Treasurer.” The last paragraph of Section 1 of Chapter IV. as amended will then read as follows:

Vice-Councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective Councilors, when they shall serve as Councilors. The Vice-Speaker shall be an ex-officio member of Council without the right to vote except in the absence of the Speaker, when he shall serve in the

Speaker's stead. Delegates to the American Medical Association, the Editor of the *Journal*, and the Executive Director shall be ex-officio members of Council without the right to vote.

3. Amend Chapter IV., Section 3, by inserting in line 4 thereof between the word "Secretary" and the word "the" the words "the Treasurer." Section 3 of Chapter IV. as amended will then read as follows:

SECTION 3. EXECUTIVE COMMITTEE. The Council shall organize an Executive Committee at the organization meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the First Vice-President, the Secretary, the Treasurer, the Chairman of Council, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. The Second Vice-President and the Speaker of the House of Delegates, or in his absence, the Vice-Speaker, shall be ex-officio, non-voting members of the Executive Committee. The Executive Committee shall meet monthly between meetings of Council. At any duly called meeting of the committee for which proper notice has been given, any three (3) members of the Committee shall constitute a quorum. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it. The Executive Committee shall appoint all Association Committees, including chairmen, and shall nominate members for all Boards required by the laws of the State of Georgia on recommendation of the district societies where applicable, not otherwise provided for, subject to confirmation by Council and shall serve as Publications Committee of the *Journal*. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Director who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee between meetings of Council shall have the authority and power of Council in the field of legislative activity. The Executive Committee shall act as Board of Trustees directing the Executive Director in carrying out the mandates and policies of the Council and the House of Delegates. Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Director as to undetermined matters of policy.

4. Amend Chapter V., Section 1, line 3, by inserting therein between the word "Secretary" and the word "the," the words "the Treasurer"; also amend line 8 by inserting between the word "Secretary" and the word "and," the words "the Treasurer"; also amend the next to the last line of same section by inserting therein between the word "Secretary" and the word "or," the words "or Treasurer." Section 1 of Chapter V. as amended will then read as follows:

SECTION 1. OFFICERS AND TERMS OF OFFICE. The officers of the Association are the President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, and the Councilors and Vice-Councilors. The President-Elect shall be elected annually

and shall become President at the time of the next Annual Session. The Second Vice President shall be elected annually and shall become First Vice President at the time of the next Annual Session. The Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Councilors and Vice-Councilors shall serve for terms of three years. Delegates and Alternate Delegates to the American Medical Association shall serve in accordance with the Constitution and Bylaws of the American Medical Association and shall be elected in accordance with provisions of these bylaws consistent therewith. All other officers shall serve for one year. No member shall hold the office of Secretary, or Treasurer, or Speaker of the House of Delegates more than two consecutive terms.

5. Amend Chapter V., Section 2 by deleting the words "and of" in the second line and inserting the word "Treasurer" between the words "Secretary" and "Delegates."

6. Amend Chapter VI., Section 4, of the Bylaws by adopting a new sub-section 4(B), and redesignating the present subsection 4(B) as subsection 4(C). The new subsection 4(B) shall read as follows:

SECTION 4. TREASURER. (B) The Treasurer shall be a member in good standing for at least three years prior to his election and may not be the same member who holds the Office of Secretary. He shall be an officer of the Association and a voting member of the Council and of the Executive Committee of Council. He shall be an ex-officio member without the right to vote of the House of Delegates. The Treasurer shall give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Association.

7. Amend Chapter VIII. of the Bylaws by deleting the present Section 1, and then renumbering the present Sections 2 and 3 as Sections 1 and 2 of Chapter VIII.

This is submitted for final action of the House of Delegates.

ITEM 2: ANNUAL REPORTS

Action taken at the 1971 House of Delegates:

Be it resolved that Chapter III, Section 8 be amended so that Section in its entirety would read: "Section 8. All reports and resolutions shall be referred to the appropriate Reference Committee before action is taken by the House of Delegates; provided, however, that reports which contain no recommendations shall be referred at the discretion of the Speaker; and further provided, that any reports shall be referred to the Reference Committee when a formal request for referral is made by a Delegate from the floor of the House of Delegates. Such reports that are not referred shall be filed, as received, for information only."

ITEM 3: SUCCESSION TO THE PRESIDENCY

The following amendment to Article 9, Section 5 of the Constitution and Bylaws as related to succession of the President of MAG was approved by the House of Delegates in 1971 and is presented for final action.

Amend Article IX, Section 5, of the Constitution by the addition of a new paragraph at the end of said Section 5 to read as follows:

"In event a catastrophic occurrence shall exhaust the aforementioned line of succession to the Presidency,



the Speaker of the House of Delegates or the Vice Speaker, if the Speaker is unable to act, shall be authorized to convene an emergency meeting of the House of Delegates for the purpose of naming an Acting President to serve until the next Annual Session. The Acting President, so named, shall have all the powers and duties of the President during the term for which he is elected to serve. Should the Speaker and the Vice Speaker both be unable to act, then five Councilors or any 10 delegates shall be authorized to convene the House of Delegates in emergency meeting. Such other acting officers as necessary shall also be named at this time to serve until the next Annual Session."

ITEM 4: MEMBERSHIP REINSTATEMENT

On August 7, 1971, the Executive Committee of Council requested the Constitution and Bylaws Committee to draw up specific language for action by the House of Delegates which would specify that an individual member being reinstated for failure to pay dues should be re-worded so that the wording "one year's dues in arrears" would specify that this year would be the year immediately preceding reinstatement.

Be it resolved that Chapter VIII, Paragraph 2 be amended by striking out the words "one year's dues in arrears" and substituting the words "the dues of the year immediately preceding reinstatement." So that the sentence reads: "An active member who fails to pay dues or additional dues for one or more years shall be eligible for reinstatement upon payment of dues of the current year plus the dues of year preceding reinstatement plus payment of all dues and additional dues in arrears at the time such active member lost membership by delinquency with respect thereto subject to re-application and approval of his county medical society."

ITEM 5: MEMBERSHIP FOR OSTEOPATHS

Action of MAG Council, September 18-19, 1971: "Speaker Rogers asked the feeling of Council regarding the question of MAG membership for Osteopaths and on motion (Dowda-Collins), the Council recommended that this matter be referred to the 1972 House of Delegates and that the Committee on Constitution and Bylaws present the necessary language to the next meeting of Council."

The following language was approved for submission to the House:

"MAG MEMBERSHIP FOR OSTEOPATHS

Amend the Bylaws by designating the present Section 1 of Chapter I, without change, as Section 1, Paragraph (A). Be it further resolved that a new paragraph be added designated as Section 1, Paragraph (B). As amended Chapter I, Section 1 would then read:

CHAPTER I

Membership

SECTION 1.

(A) A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who is a citizen of the United States, and who has not been judged guilty of moral turpitude or other

serious crime, may be eligible for membership after being certified by the Secretary of a component society as being a member in good standing of said component county society and upon paying dues to this Association as hereinafter provided.

(B) A physician holding the degree of Doctor of Osteopathy from a college of Osteopathy acceptable to the Council or the Association and licensed for full practice privileges by the Composite Board of Medical Examiners of the State of Georgia, who is a citizen of the United States, and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the Secretary of a component society as being a member in good standing of said component county society and upon paying dues to this Association as herein-after provided."

ITEM 6: PAST PRESIDENTS AS HONORARY MEMBERS OF COUNCIL AND AMA ALTERNATE DELEGATES AS EX-OFFICIO MEMBERS OF COUNCIL

On December 11, 1971 the Council took the following action: "Dr. Bohler read a resolution to allow Past Presidents of MAG to be made Honorary Councilors and invited to attend all Council meetings, and to ask the Constitution and Bylaws Committee to make the necessary enabling changes. On motion duly made and seconded, this resolution was approved."

On February 11, 1972 the Council took the following action: "Council heard the recommendation that the Constitution and Bylaws Committee prepare language to make the Alternate Delegates to the American Medical Association Ex-Officio members of Council without the right to vote. This motion (Dowda-Eldridge) was adopted."

This may be accomplished in the Constitution by inserting between the words "Delegates to" the words "and Alternate Delegates" in the second sentence to Article VI, Section 1, Composition. Also in the same sentence by inserting between the words "*Journal* and" the words "Past Presidents" so that the sentence would read as follows:

"Delegates and Alternate Delegates to the AMA, the Treasurer, Editor of the *Journal*, Past Presidents, and the Executive Director shall be Ex-Officio members of Council without the right to vote."

The following changes would be required in the Bylaws in order to accomplish these recommendations:

"Chapter 4, Section 1, Composition:" The first sentence is changed by inserting the following between the words "House of Delegates and Councilors." the words "Past Presidents," so that the sentence would read as follows: "The Council is composed of the President and President-Elect, Immediate Past President, who shall serve as a full member of Council for a period of three years, two Vice Presidents, Secretary, Speaker of the House of Delegates or Vice Speaker of the House of Delegates, Past Presidents and Councilors or Vice Councilors selected as follows:"

The last Paragraph of Chapter 4, Section 1, Composition is changed as follows: The last sentence of the last paragraph would be changed by inserting between the words "Delegates to" the words "and Alternate Delegates"; and also adding between the words "*Journal*, and" the words "Past Presidents.". So that the last

sentence of Section 1 would read as follows: "Delegates and Alternate Delegates to the American Medical Association, the Editor of the *Journal*, Past Presidents, and the Executive Director shall be Ex-Officio members of the Council without the right to vote."

Liaison Committee with Composite Board of Medical Examiners

C. E. BOHLER, M.D., and ALBERT M. DEAL, M.D.

The Liaison Committee suggests extending on a continuing basis an invitation to all individuals holding an unrestricted license for the practice of medicine issued by the Composite Board of Medical Examiners to become members of the Medical Association of Georgia.

It is pointed out that there are two Osteopaths on the Composite Board of Examiners and these men participate in disciplinary procedures and licensing procedures of all people seeking an unrestricted license for the practice of medicine.

Having brought certain qualified Osteopaths into the mainstream of medicine and having granted them an unrestricted license and having provided for the eventual future in that there will be no Osteopaths who do not meet unrestricted license provisions, it would seem that we could best provide continuing education and possibly disciplinary control if they are allowed and encouraged to become active in organized medicine as represented by M.A.G. and its component societies.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee considered each item of the Constitution and Bylaws Committee report separately and makes the following separate recommendations:

Item 1 proposes that the Treasurer become an elected officer of the MAG with full voting rights on Council and the Executive Committee of Council. Pages one through four deal with the appropriate amendments, both technical and substantive, to accomplish these purposes. The reference committee recommends approval and observes that the House of Delegates approved this, in principle, at their 1971 meeting;

Item 2 is designed to expedite the business of the House of Delegates by deleting the Bylaws requirement for all reports to be referred to reference committees. This action was recommended by the 1971 House of Delegates and your reference committee recommends approval at this time;

Item 3 provides for the orderly succession to the MAG Presidency in the event of a catastrophic occurrence that eliminated all elected successors. Like Item 2, this was also approved by the House of Delegates last year and is submitted now with approval for formal adoption;

Item 4 stipulates that reinstatement of lapsed MAG membership be conditioned, among other requirements, upon the payment of one year's dues in arrears and that the specific year shall be the one immediately preceding the year in which reinstatement is sought. This is the only change made by Item 4 of the report and your reference committee recommends approval.

Item 5 and Committee Report 72-3—Liaison Committee with Composite Board of Medical Examiners, were considered together as they both relate to the

same proposed change in the Bylaws. Adoption of Item 5 would amend the Bylaws to make MAG membership available to osteopaths. The committee received lengthy testimony on this matter. The committee noted that an actual request for MAG membership had not been received. The committee further noted that the House refused to approve this amendment last year. Accordingly, the reference committee recommends disapproval of both Item 5 and Committee Report 72-3 with an additional recommendation that Executive Committee of Council appoint a liaison committee with the Georgia Osteopathic Association to further explore the possibilities of MAG membership for osteopaths with full practice licenses;

Item 6 provides that all past MAG Presidents become Honorary members of Council (without the right to vote) and that AMA Alternate Delegates be made ex-officio members of Council without the right to vote. Your reference committee recommends approval of Item 6 feeling that much expertise and knowledge of organized medicine would otherwise be lost to the Association.

HOUSE OF DELEGATES ACTION—It was noted that item 1 had been previously approved by the House in order to facilitate balloting for office of Treasurer. The House then adopted the report as recommended by the reference committee.

National Legislation Committee

J. FRANK WALKER, M.D., *Chairman*

At the national level two issues, on a short haul basis, occupy majority attention from organized medicine during the early months of the last half of the 92nd Congress. These are: chiropractic and national health insurance.

1. Chiropractic—H.R. 1, Social Security amendments, contains numerous changes in the Medicare, Medicaid and welfare programs. This bill has been slow working its way through the Congress, having passed the House in 1971. As of the date of this report (4/14/72), H.R. 1 is still pending in the Senate Finance Committee. The Finance Committee has included an amendment to cover chiropractic services under Part B "to the extent it involves treatment by means of manual manipulation of the spine by a chiropractor meeting minimum standards established by the Secretary of HEW."

In private meetings with officials in Washington, we have been told that this amendment will pass the Senate, but there is a strong likelihood that it will be deleted from H.R. 1 by a Conference Committee of the House and Senate as they attempt to work out differences between the House passed and Senate passed versions of this bill. Your Committee will continue to push for defeat of the Senate Finance Committee chiropractic amendment.

2. National Health Insurance—As of this date there are five members of the Congress from Georgia who have introduced (or co-sponsored) the AMA promoted "Medicredit" bill. They are: Congressman Elliott Hagan (First District); Benjamin Blackburn (Fourth District); Fletcher Thompson (Fifth District); William Stuckey (Eighth District); and Robert Stephens (Tenth District). In its simplest form, the Medicredit bill is designed to give maximum help to those unable to help themselves and minimum help to those able to

pay their own way. To accommodate the people between these two extremes, a sliding scale, based on the amount of income tax paid, is used to determine the amount of federal help one (or family) would receive.

If a person or family owes no federal income tax for the year because he has no income, low income, or a large number of dependents, the total cost of basic and catastrophic coverage would be paid by the Federal government. The family would receive a "Certificate of Entitlement" which would cover the entire premium or membership cost for an approved program from whatever insurance company or plan the family chooses.

For those families or individuals who pay federal income tax, the formula is most complicated. The cost of the approved policy (or plan) is divided into two parts. Most of the cost will go for basic coverage; a smaller portion is for catastrophic coverage. The insurance company will determine how much is paid for each.

It will pay a percentage of the cost based on the amount of income tax the family or individual owes. As income goes up, the federal contribution comes down.

The MAG House of Delegates endorsed the concept of Medigap at its meeting last year as being the most logical answer to the national health insurance matter to be presented to date.

It is considered unlikely that a final vote on any kind of comprehensive national health insurance will take place this year. This will, of course, make national health insurance a prime political issue during the 1972 Presidential election.

A bill that has great potential interest to the medical profession (particularly in Georgia in view of the emergence of the Department of Human Resources) is one introduced by Senator Abraham Ribicoff of Connecticut. The Ribicoff bill provides for the establishment of a separate Department of Health, not a part of the HEW complex. Senator Ribicoff was Secretary of the Department of Health, Education and Welfare under President Kennedy. This bill, most surely, will not be enacted this year, but it is one that your Committee will watch with interest in the years immediately ahead.

ANNUAL CONGRESSIONAL LUNCHEON—The 1972 annual Congressional luncheon was held on April 13, in Washington. As in the past each member of the Georgia Delegation from the House and Senate was invited to attend our luncheon and each was hosted personally by a physician constituent. On this occasion all members of the House were present. Senator Talmadge was unavoidably detained on the floor of the Senate and Senator Gambrell was in Georgia. Senator Gambrell sent his Administrative Assistant to represent him, and Senator Talmadge received our delegation in his office after the luncheon.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee approves with commendation the report of the Committee on National Legislation and recommends that it be received for information by the House as no recommendations were contained therein.

HOUSE OF DELEGATES ACTION—Adopted the report of the committee on National Legislation as recommended by the reference committee.

The dominant issue of the 1972 General Assembly was, of course, the Governor's plan for reorganization of the Executive Branch of State government. It overshadowed all other matters and frequently obscured them to the point that they failed to receive the kind of attention they would have received in other years.

The Human Resources concept as offered by the Governor was the central issue of reorganization. Because of its far reaching consequences it commanded the great majority of MAG's time and attention. A full scaled campaign was organized and carried out and defeat of this issue became the almost full time legislative objective of the Association.

There seems little doubt that the overall legislative position of MAG was damaged during this long and frequently bitter session. It seems equally obvious that some means of fully re-establishing MAG as the authoritative voice of medicine at the Capitol is a matter that must be given high priority.

While reorganization over-shadowed all other matters during the 1972 Session, nonetheless other items of importance to the profession were considered and disposed of by the General Assembly. High on the list were bills dealing with "physician's assistants," and Chiropractic. These bills and other bills of interest to MAG are discussed in more detail as follows:

NOTE: As of the writing of this report none of the bills described herein have been signed into law by the Governor. Your Committee on State Legislation anticipates making a Supplemental Report to advise the House of the final action taken by the Governor.

(1) **HUMAN RESOURCES (H.B. 1424)**—This portion of the Governor's reorganization proposal abolished the Board of Health, combined the Department of Health with the Departments of Welfare, Vocational Rehabilitation and several lesser agencies to create a Department of Human Resources. It created a 15-man Board of Human Resources consisting of five physicians, two health related people and eight laymen. The bill further provides for a Division of Mental Health separate and apart from the Division of Physical Health. The Governor has indicated in private discussions that he will include a pharmacist and a dentist among the non-physicians appointed to the Board. MAG will participate (by statute) in a Medical Nominating Committee to select 25 physicians from which the Governor must choose five for appointment to the Board of Human Resources. A copy of the House and Senate voting record on this matter is attached and becomes a part thereof. **PASSED.**

(2) **CHIROPRACTIC (S.B. 474)**—This bill would have compelled all health and accident insurance policies to include reimbursement for services rendered by Chiropractors. As introduced the bill also covered Workmen's Compensation and Medicaid. Medicaid, however, was amended out of the bill in the House Committee. S.B. 474 passed the Senate 31 to 9, was favorably reported from the House Insurance Committee. The House Rules Committee, and very narrowly defeated on the floor of the House (approximately 15 minutes prior to midnight adjournment deadline on the last day of the Session). In the House all bills must receive a constitutional majority of 98 votes to

pass. The Chiropractors, encouraged by their "near win," are certain to reintroduce their bill again next year. They will have had an opportunity to lobby for their bill during a campaign year and MAG must expect another strong push to enact this legislation. House and Senate voting records on this bill are attached and made a part of this report. **DEFEATED.**

(3) **PHYSICIAN'S ASSISTANT (H.B. 1591 & 1592)**—H.B. 1591 was a technical bill to authorize certain people to engage in the limited and controlled practice of medicine without a license to practice medicine: In short, an exception to the Medical Practice Act. H.B. 1593 is the bill that actually creates physician's assistants as a new category of health care personnel. A copy of the full bill will be made available to the Reference Committee for their study. Points of significant interest in this bill are:

(a) Definition of physician's assistants is "Physician's Assistant means a skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of the applying physician."

(b) Applications to utilize a physician's assistant shall only be made by licensed M.D.'s or D.O.'s to the Board of Medical Examiners and must include a description of the physician's practice and the way in which the assistant is to be used.

(c) No physician shall have more than two Physician's Assistants in his employment any one time.

(d) Physician's Assistants shall be authorized to perform their duties only in the principal offices of the physician with whom they are employed. However, they may be used in making house calls, and conduct hospital rounds.

(e) MAG efforts to amend the bill to restrict its application to those physicians engaged in private practice failed. However, we were able to secure an amendment to restrict the use of Physician's Assistants by public health physicians to those engaged in treating patients—administrative physicians could not employ Physician's Assistants.

(f) The Board of Medical Examiners is authorized to adopt rules that will exempt qualified medical employees from this act when they are performing functions permitted by law or custom. **PASSED.**

(4) **INTERNSHIP (H.B. 548)**—MAG sponsored legislation (carried over from last year) that permits the Board of Medical Examiners to accept a clinical training program other than an internship as a condition of licensure was **PASSED.**

(5) **OPTOMETRY (H.B. 1417)**—The optometrists hailed this bill as a "freedom of choice" bill only. It was much more. It would have restricted any agency of government which had assumed responsibility for paying for the health care of any citizen from referring that person to an M.D. for diagnosis or treatment of any condition that comes within the scope of practice of an optometrist. To do so would have constituted an act of illegal discrimination under this bill. Extensive hearings held by the House Health and Ecology Committee resulted in the defeat of this bill. **DEFEATED.**

(6) **CLINICAL LABORATORIES (S.B. 615 & S.B. 389)**—S.B. 615 provides that persons who hold Doctorate Degrees shall be eligible to be directors of clinical laboratories. Previously, Georgia law stipulated

that only M.D.'s could be clinical laboratory directors. Senate Bill 389 provides that clinical laboratories (which collect, store and process blood) must adopt regulations which conform to the "Standards for Blood Banks and Transfusion Services" most recently published by the American Association of Blood Banks. **BOTH BILLS PASSED.**

(7) **ABORTION (H.B. 647)**—A substitute abortion bill which incorporated all the points agreed to by the 1971 House of Delegates (except restricting procedure to JCAH only) was favorably reported from the House Health and Ecology Committee. It was subsequently defeated on the floor of the House. **DEFEATED.**

(8) **HYPNOSIS (H.B. 2036)**—MAG sponsored legislation to restrict the use of hypnosis to physicians, dentists, optometrists and clinical psychologists (on referral from M.D.'s only). Use of hypnosis by anyone other than those named above (except when self-induced) would have been contrary to law. The bill was defeated in the House Health and Ecology Committee. **DEFEATED.**

(9) **BLUE SHIELD (H.B. 1845)**—This bill would have given the Insurance Commissioner (Comp. General) the authority to cancel the charter of Blue Cross-Blue Shield Plans for failure to perform certain acts. No provision was made for an appeal from an adverse decision of the Commissioner. The bill passed the House but was not voted on in the Senate. **DEFEATED.**

(10) **TRAFFIC SAFETY**—Four traffic safety bills supported by MAG were enacted. They were: H.B. 370, a bill to regulate the licensing of ambulance services to include first aid training for operators; H.B. 58, a bill to require periodic re-examination for visual acuity as a condition for reissuance of a driver's license; H.B. 59, a bill to establish a classification of drivers' permits (auto, motorcycle, truck, etc.); and H.B. 1389, a bill designed to identify and effectively deal with habitual offenders of traffic safety laws. **PASSED.**

(11) **CERTIFICATE OF NEED (S.B. 341)**—This bill would have required approval by the Health Department in order to expand existing hospital or build a new hospital. MAG opposed this bill. **DEFEATED.**

(12) **COUNCIL ON MATERNAL HEALTH (H.B. 1044)**—This bill provides for the Governor to appoint a 10-man Council on Maternal Health. The Council is to be composed of obstetricians, nurses, hospital administrators, public health physicians and educators. The Council is supposed to represent a cross section of professional and institutional personnel. It will serve in an advisory capacity and will concern itself with all phases of maternal health. **PASSED.**

(13) **DOCTOR-OF-THE-DAY**—This program continues to draw warm praise from members of the House and Senate and remains MAG's most visible public relations endeavor. Your Committee on State Legislation wishes to take this opportunity to sincerely thank all those who participated in this program, and in particular wishes to extend its appreciation to Drs. Charles Watkins and James Kaufmann, Co-Chairmen for the project. In addition, we wish to publicly acknowledge the assistance of Mr. Charles Burge, Associate Administrator at St. Joseph's Infirmary, Atlanta, for making available the services of Mrs. Doris Boyd as our nurse for the full session of the General Assembly.

COMMENDATIONS—(1) This past session of the General Assembly was one of the most grueling that anyone at MAG can recall. Without the assistance of many hometown physicians, too numerous to mention here, the job of the Legislative Committee would have been impossible. We want to take this opportunity to thank each of them sincerely and to add that without their support MAG would have had no success at all in their legislative program. (2) In addition, your Committee wants to call special attention to the support it received from the Medical Association of Atlanta and in particular the effective services of their Executive Director, Mr. John Kiser.

RECOMMENDATIONS

(1) It is apparent that MAG needs considerably more help with its legislative program. The number of bills introduced and their complexity make necessary that we “beef up” lobbying and other legislative efforts. Accordingly, we would like to recommend that extensive use of the MAG Field Representatives be made to augment the legislative program and that their full-time services be made available to the legislative effort from December through adjournment of the General Assembly.

(2) Chiropractors missed by two votes having their compulsory insurance bill enacted this year. For the past several years your Committee on Legislation has recommended that County Medical Societies take the matter of Chiropractic seriously and develop a dialogue with local Representatives and Senators to prevent what almost happened this year. Your Legislative Committee once again urges that all County Medical Societies set aside one meeting during the year to invite your Senators and Representatives to attend for a frank, open discussion of this serious matter.

(3) Our able and dedicated “man at the Capitol,” Mr. Jim Moffett, did an unbelievable amount of work this year. He was called on to almost singlehandedly take on the entire administrative department of State Government. He had the impossible task of adding to this full-time job, his usual duties of keeping up with all medically significant bills introduced. Keeping up with where these bills were at any given moment and trying to arrange for expert testimony in committee was an impossible task which he accepted with his usual competence. As literally dozens of MAG members will attest, his job continued until late each night as he called on them individually to contact their local legislators to effect one phase of legislation. Mr. Moffett was hopelessly outnumbered and needs our help in this vital job.

This Committee recommends that the superb efforts of Mr. Moffett be officially brought to the attention of this House of Delegates and to the Executive Committee.

State Legislation Committee

HARRISON L. ROGERS, JR., M.D., *Chairman*

As of the date on which the Report of the Committee on State Legislation was filed with the House of Delegates the ultimate status of certain bills of interest to MAG was unknown.

Under Georgia law the Governor has 30 days (excluding Sundays) in which to sign or veto bills or permit them to become law without his signature.

The following bills of interest to MAG have been signed into law:

H.B. 58 (Act No. 1491)—Periodic re-examination for visual acuity for driver's license.

H.B. 59 (Act No. 1492)—Establish classification of driver's licenses.

H.B. 370 (Act No. 1199)—License and regulate ambulances.

H.B. 548 (Act No. 1301)—Medical Examiners Board accept clinical training program in lieu of internship for licensure.

H.B. 1044 (Act No. 1201)—Creates Council on Maternal Health.

H.B. 1389 (Act No. 1495)—Habitual offender—identify and punish.

H.B. 1591 (Act No. 1207)—Provides for physician's assistant as an exception to the Medical Practice Act.

H.B. 1592 (Act No. 1208)—Sets scope of practice and method of becoming a physician's assistant.

S.B. 389 (Act No. 1558)—Provides that blood facilities adopt American Association of Blood Banks “Standards for Blood Banks and Transfusion Services.”

S.B. 615 (Act No. 1564)—Authorize Ph.D.'s to be Clinical Laboratory Directors.

The Governor did not veto any bills of interest to MAG.

REFERENCE COMMITTEE RECOMMENDATION
—These reports were considered together and it is recommended that both be approved with commendation with the additional recommendation that copies of the Physician's Assistant Bill (H.B. 1591 & H.B. 1592) be sent to all County Medical Society Presidents and that they be urged to call these bills to the attention of their membership; and further, that copies of these important bills be made available to the entire membership on request.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on State Legislation and Supplemental Report of the Committee 72-1 as recommended by the Reference Committee.

Resolution 72-1

Change in Qualifications for Membership to the Medical Association

BALDWIN COUNTY MEDICAL SOCIETY

WHEREAS, the Georgia State Law to practice medicine has been amended to permit certain aliens to practice medicine in the State of Georgia (Georgia Code Chapter 84-907.5); and,

WHEREAS, the present Bylaws of the Medical Association of Georgia does not permit these physicians to become members of our Association; and,

WHEREAS, the importance that all licensed practicing physicians in the State of Georgia be permitted to become members of the Medical Association of Georgia is recognized; therefore be it

RESOLVED BY THE BALDWIN COUNTY MEDICAL SOCIETY at its regular meeting on February 9, 1972, that the Bylaws of the Medical Association of Georgia be amended so that physicians that have obtained their Georgia State License under the Georgia State Law 84-907.5, be permitted to become members of the Medical Association of Georgia. This law states

that these physicians must have filed an intent to become a United States Citizen and must become a citizen within seven years.

REFERENCE COMMITTEE RECOMMENDATION
—This resolution proposes the repeal of citizenship as a condition of membership in MAG. Your reference committee recommends approval of this resolution when amended as follows: On line 15 following the word physicians, add “holding the M.D. degree” and by deleting from line 16 the words “under the Georgia State Law 84-907.5”, and by deleting in their entirety lines 18, 19 and 20. So when amended the resolved portion of the Resolution will read: “RESOLVED BY THE BALDWIN COUNTY MEDICAL SOCIETY at its regular meeting on February 9, 1972, that the Bylaws of the Medical Association of Georgia be amended so that physicians holding the M.D. degree that have obtained their Georgia State License be permitted to become members of the Medical Association of Georgia.

HOUSE OF DELEGATES ACTION—Adopted Resolution 72-1 as recommended by the reference committee.

Supplemental Report 72-3
Retention of Present Councilor Districts

C. E. BOHLER, M.D., *Chairman*

The Committee on Long Range Planning was appointed to study the effects of Congressional redistricting in the organizational structure of MAG: Council, District Medical Societies, other medical society entities that relate to or are affected by Congressional District lines, and public agencies.

The Committee on Long Range Planning is giving study to a system that will not require changing every time the General Assembly is forced to redraw Congressional District lines. It is a complex undertaking.

RECOMMENDATION

Until this study is completed and adopted by the House of Delegates it is recommended that the present Councilor Districts be retained and that they continue to serve as the basis on which to resolve all matters now related to District Medical Societies.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends receiving of this report for information.

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report 72-3 as recommended by the reference committee.

Resolution 72-4
Change in Bylaws to Permit Physicians Who Retire at 62 or Are Permanently Disabled to Retain Membership

MENARD IHNEN, M.D., *Delegate*

BE IT RESOLVED, that the Bylaws of the Medical Association be amended to permit physicians who retire from practice after sixty-two years of age or at any age if permanently disabled may retain membership in the Medical Association of Georgia without the

right to vote or hold office and without the requirement of payment of dues.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this Resolution as amended by deleting the word “after” on line 2, by deletion of all of line 3 and changing the word “may” to “to” on line 5. As amended this resolution would read: “BE IT RESOLVED, that the Bylaws of the Medical Association of Georgia be amended to permit physicians who retire from practice to retain membership in the Medical Association of Georgia without the right to vote or hold office and without the requirement of payment of dues.”

Your reference committee makes the additional recommendation that this matter be referred to the Committee on Constitution and Bylaws for drafting the appropriate language and to bring back to the 1973 House of Delegates for a vote.

HOUSE OF DELEGATES ACTION—Adopted Resolution 72-4 as recommended by the reference committee.

Resolution 72-5
Attorney General’s Ruling on Podiatric Practice Privileges
LUTHER H. WOLFF, M.D.

WHEREAS, on July 22, 1971, Arthur K. Bolton, Attorney General of the State of Georgia, issued a ruling stating that Podiatrists are “licensed Doctors of Medicine” or “doctors of medicine licensed to practice medicine in this State”; and,

WHEREAS, this ruling arbitrarily and automatically places Podiatrists on an equal footing and status of individuals holding degrees of Doctors of Medicine; and,

WHEREAS, this ruling was obviously made with no regard for an account of training, competency, or basic scientific qualifications; and,

WHEREAS, Podiatrists are not required to complete a post-graduate program approved for such purpose by the Composite State Board of Medical Examiners, nor are they required to pass the examination given by the Composite State Board of Medical Examiners, and,

WHEREAS, Podiatrists attempt, and claim to be able, to perform many complicated and serious procedures on the foot and leg, which, in fact, are often a manifestation of a general bodily disease or process; and,

WHEREAS, this ruling will tend to negate the strict supervision and control established by laws to protect the public from inadequately trained and uncontrolled individuals endeavoring to practice the healing arts and sciences,

NOW, THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia forthwith contest and challenge this ruling of the State Attorney General Arthur K. Bolton regarding Podiatry with every legal means in its power.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this Resolution when the resolved portion is re-written as follows:



H. E. Godfrey, M.D., from Manchester, England, speaking on "Government Controlled Medical Care."

"NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia forthwith contest and challenge the ruling of the State Attorney General Arthur K. Bolton which states that Podiatrists are 'licensed Doctors of Medicine' or 'doctors of medicine licensed to practice medicine in this state'." The reference committee felt that a general re-writing of the resolved portion was needed in the interest of clarity.

HOUSE OF DELEGATES ACTION—Adopted Resolution 72-5 as re-written by the reference committee.

Resolution 72-6

Free Choice of Billing Under Medicaid

C. J. ROPER, M.D.

WHEREAS, the practice of medicine is subject to increasing controls by the Federal Government, and

WHEREAS, this is in evidence particularly under the Medicaid Law wherein physicians are not allowed to exercise free choice of billing, and

WHEREAS, the foregoing is contrary to the free enterprise concept, and

WHEREAS, we are all in favor of the free enterprise practice of medicine,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia go on record in opposition to the system that prohibits free choice of billing and that the MAG express its strong objection to all of our Congressmen and Senators on this matter.

REFERENCE COMMITTEE RECOMMENDATION—In considering this resolution your reference committee took cognizance of the many inequities in the Medicare, Medicaid and welfare systems. However, it feels that adoption of Resolution 72-6 would offer no constructive improvements in the situation, while at the same time it may provide a further deterioration of the physician's image. Accordingly, your reference committee recommends disapproval.

HOUSE OF DELEGATES ACTION—Delegate F. William Dowda moved that Resolution 72-6 be re-

ferred to the MAG Council for disposition. This motion was adopted by the House.

Resolution 72-7

Recovery of Costs Incurred in Fee Collections

CHARLES E. TODD, M.D.

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia investigate insurance policies which provide for payment of legal expenses, court costs, and penalties for policyholders in cases where physicians seek to recover legitimate fees from delinquent patients.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee was presented with a printed item taken from the April 24, 1972, issue of *Medical Economics* (page 40) as follows:

TALK ABOUT THIRD-PARTY INTERFERENCE!

"Aetna Life & Casualty is telling patients that if a doctor sues them for the difference between his full charge and what Aetna allows for a procedure, the firm will back up the patient in court. Aetna says it will pay a patient's legal expenses, plus court costs and penalties, if the court rules for the doctor."

The reference committee felt that no third party should attempt to set doctor's fees and accordingly recommends approval of Resolution 72-7 with the inclusion of an additional "resolve" so that the Resolution would then read:

"NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia investigate insurance companies which provide policies under which payment of legal expenses, court costs, and penalties in behalf of policyholders in cases where physicians seek to recover legitimate fees from delinquent patients, and

"BE IT FURTHER RESOLVED, that Council take appropriate action on the State level and refer the matter to the AMA for appropriate action on the national level."

HOUSE OF DELEGATES ACTION—Adopted Resolution 72-7 as amended by the Reference Committee.

Resolution 72-9

Legislative Indoctrination Sessions

JAMES A. KAUFMANN, M.D.

RESOLVED, that the Medical Association of Georgia have a legislative indoctrination session or meeting for all members in November or December of each year,

AND BE IT FURTHER RESOLVED, that the Medical Association of Georgia encourage and make appropriate arrangements for each member to spend one day per annum at the Georgia General Assembly.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee recommends approval of Resolution 72-9 when re-written as follows:

"RESOLVED, that the Medical Association of Georgia consider having a legislative indoctrination session or meeting in November or December each year,

“AND BE IT FURTHER RESOLVED, that the Medical Association of Georgia encourage and make appropriate arrangements for each member to spend time at the Georgia General Assembly.”

In addition your committee recommends that information pertaining to medically related legislation be forwarded to all County Medical Societies for distribution to their membership.

HOUSE OF DELEGATES ACTION—Adopted Resolution 72-9 as re-written by the Reference Committee.

Chairman Turk expressed his appreciation to the members of Reference Committee B for their time and efforts and moved that the report of Reference Committee B as a whole as amended be adopted. This motion was duly seconded and approved.

Report of Reference Committee C

C. W. Whitworth, M.D., *Chairman*

Chairman Whitworth reported to the House that all reports and resolutions referred to Reference Committee C had been considered by the Committee which met at 9:00 a.m., in the Cherokee Room, Macon Hilton Hotel, Macon, Georgia, on May 13, 1972. Members of the Committee present included: C. W. Whitworth, M.D., Gainesville, Chairman; Robert W. Oliver, Jr., M.D., Dublin, Vice Chairman; F. M. Johnston, M.D., Savannah; B. Robinson Maughon, M.D., Columbus, Mikell B. Karsten, M.D., Tifton and Robert E. Wells, M.D., Atlanta.

Education Committee

J. RHODES HAVERTY, M.D., *Chairman*

This report represents the first report of this new “umbrella” committee to this House of Delegates. Since this House met last, the Committee on Education was formed by the Executive Committee with concurrence of Council. The Committee consists of three major subcommittees: the Subcommittee on Education, chaired by Dr. Luther Fortson of Marietta; the Subcommittee on Nursing, chaired by Dr. John Page Wilson of Atlanta; the Subcommittee on the Allied Health Professions, chaired by Dr. John Godwin of Atlanta. Each of these subcommittees is further divided into task forces, representing areas of emphasis appropriate to that particular subcommittee.

It was felt that the area of education of the health professions involved so many overlapping interests that a combined, overall committee could best serve the purposes of the Medical Association of Georgia. I agree with this philosophy, and feel that the committee has made real progress in addressing itself to the problems related to the production of health professionals at the basic level, and to the continuing education of these workers, including physicians, once they begin the provision of health services to our patients.

I would like to make a few brief remarks as chairman of the overall committee, and then allow the subcommittee chairmen to speak for themselves by their own reports to this House.

The Physicians and the population of Georgia as a whole can look with pride at our two medical schools, the Medical College of Georgia and the Emory University School of Medicine, as they strive to increase medical school enrollment, and thereby increase the production of practicing physicians in our state.

The biennial Conference on Medical Education again will be scheduled for the winter of 1973, in February or March. This has been a most successful and enthusiastically accepted MAG-sponsored conference, and is always looked forward to and participated in by practicing physicians and medical school faculty of our state.

The members of the Committee on Education, particularly the subcommittee chairmen, have attended national and state conferences in their respective areas, and these meetings have been beneficial to the state by introducing new ideas for discussion and possible implementation. Not the least advantage of these conferences and our attendance, however, has been to show the nation the leadership that Georgia takes in the field of medical education, nursing education, and the education of allied health professions.

Partly as a result of my recommendation as Chairman of the Medical Education Committee in 1970, a new addition to the Headquarters Office staff of the Medical Association occurred in the person of Mr. Adam Jablonowski. Among his many other duties, Mr. Jablonowski has staffed the Committee on Education and its subcommittees and their task forces. He has served ably in this capacity as well as in his other duties as a member of our central headquarters office staff, and in my opinion has fulfilled the fondest hopes of those of us who were responsible for urging the employment of such a person, and in choosing him to fill this position.

The following represent the subcommittees’ reports by their respective chairman. The first is that of Dr. John T. Godwin, Chairman of the Subcommittee on Allied Health Professions:

“A formal meeting of the Subcommittee has not been held although informal discussions have been carried on with various representatives and organizations in attempting to keep abreast of various programs and projects within the state and nationally.

“It is expected that the chairman will work closely with the new careers representative of the Medical Association of Georgia in continuing recruitment efforts.”

“The Subcommittee on Nursing Education has had two meetings for the purpose of delineating the areas of activity. The two principal problems in Nursing Education which seem to be most appropriate for evaluation are: first, the continuing Education Program in individual hospitals, and, second, the curricula of nursing schools. The related problems were probed at some depth and with the following basic conclusions, that some general concept of the role of the nurse in the overall delivery of health care must be defined in order to determine the appropriateness of the educational system, both in terms of nursing education and continuing on-going education of the nurses. It is anticipated that two task forces, directed toward these two basic needs, will be developed.

“The Chairman of the Committee has attended the Annual Meeting of the Georgia State Nurses Association and considerable rapport was established with this group in developing a conjoint study group. The needs

of the nurses, which were expressed at this time, were: (1) the evaluation of the utilization of nurses, (2) additional support financially, with the encouragement of physicians to support the current bills for financial underwriting of Nursing Education that are in Congress, and (3) to strengthen the Georgia State Nurses Association.

"The planned meeting of the Georgia Education Improvement Council, of which the Chairman of the Committee is a member, was scheduled to meet in December, but the meeting has been postponed. The result of this meeting will have a considerable influence on the direction of the Nurses Educational Committee.

"Dr. Neil Perkinson, a member of the Committee, attended the recent meeting concerning nurse practitioners with some very pertinent observations about the development of this program.

"It is felt by the Committee that we have established an excellent liaison with the nursing organizations and are in a position, with the support of the Association, to make some real accomplishments in the area of nursing education.

"Two task forces, composed of physicians and nurses, have been established for Continuing Nursing Education and Nursing Education and Nursing School Curricula. It is expected that as these groups meet more joint positions will be developed for the MAG and the GHNA."

One additional comment by me on this issue concerns the establishment of a Joint-Practice Committee of physicians and nurses for the State of Georgia. I serve on a National Advisory Committee of the National Commission for the Study of Nursing and Nursing Education, which is pressing for the establishment of state Joint-Practice Committees to help solve some of the problems that have arisen between the medical profession and the nursing profession, particularly as they concern the education and practice of these individual professions and how they relate to each other, and to the patients whom they serve jointly. I urge the establishment of such a Joint-Practice Committee in Georgia and the active involvement of the Subcommittee on Nursing in the establishment and function of this committee in our State.

The last report is that of the Subcommittee on Medicine, chaired by Dr. Luther Fortson, which follows. I would like to comment particularly on the recommendations of this subcommittee, found at the end of the report. I would like to support the first five recommendations, and give particular emphasis to Recommendation # 2 and # 4.

As regards Recommendation # 2, the Medical Association of Georgia already has begun correspondence with the AMA toward the setting up of an accreditation process, undertaken by the MAG, for postgraduate programs conducted by our two medical schools, teaching hospitals, county societies, and others. This should be a statewide function, and I would urge approval by this House for this concept. It would be the intention of the Committee on Education to provide, for consideration by this House in 1973, the guidelines under which such accreditation would be conducted.

Also, I would urge approval by this House of Recommendation # 4. Progress already is being undertaken through our Committee on Professional Con-

duct and Ethics, under the able leadership of Dr. Tom Sappington, in conjunction with our State Board of Medical Examiners, with our liaison, Dr. Emory Bohler, Chairman of our Council, helping to pave the way.

"The Subcommittee on Medicine of the Medical Association of Georgia's Committee on Education is subdivided into task forces on continuing education, clinical facilities, medical practice, and medical schools; the task forces have accepted their charges, addressed themselves to the issues, and identified certain problems.

"The shortage of primary care physicians in our state is compounded by the problem of maldistribution, so that many citizens find it most difficult to enter the health care system; and, unless some method of increasing the accessibility of medical care is devised, there will be increasing pressure by the public upon government to 'do something.' If there be a revolution in medical care, the impetus will probably come from the middle class and not from the ghetto.

"There has been no mechanism for assuring continuing competence of physicians; not from organized medicine, not from state licensing body. An unrestricted lifetime state license seems to be an anachronism in our time.

"Adequate peer review has been much discussed, but has not yet been completely implemented, though effective Peer Review is a reality in many areas of the state.

"Continuing medical education has been fragmented at best, often neglected, and sometimes virtually nonexistent.

"Medical schools have not always been sensitive to the needs of the practitioner, particularly in postgraduate education. (It has been aptly stated that attempting to teach medicine in a university hospital is analogous to teaching forestry in a lumber yard.)

RECOMMENDATIONS

"Our subcommittee submits the following recommendations for consideration:

"(1) The development of area 'facilities of excellence' throughout the state, with a two-way interchange of information and talent between the area facilities and the medical schools is felt to be the most satisfactory method of providing continuing education for physicians, recruitment and training of allied health professionals, and the education of patients and the public in health care. These area facilities may also participate in the education and training of medical students and House officers, and may well stimulate more interest in the practice of primary medicine as a career.

"(2) The Medical Association of Georgia should assume the responsibility for the accreditation of local postgraduate programs for continuing medical education as recommended by the American Medical Association's Committee on Medical Education; and MAG should begin now to establish a body of physicians whose function would be to evaluate the quality of postgraduate medical education within the state. This body should be composed of medical and surgical practitioners, directors of medical education programs, medical school educators, and officers of MAG.

"(3) The Medical Association of Georgia should endorse the concept of requiring minimum standards

of continuing education for maintaining membership in society; such a standard might be that each member receive, or be eligible to receive, the Physicians Recognition Award of the AMA, or its equivalent. It is suggested that this begin on July 1, 1973.

“(4) The Medical Association of Georgia should urge the State Legislature to amend the laws of Georgia concerning the State Board of Medical Examiners, giving that board disciplinary power, for protection of the general public and the medical profession from incompetent, dishonest and/or otherwise unfit physicians. Further, MAG should encourage legislation that will provide immunity from litigation to physicians who serve on review committees, regarding information discovered in these reviews, and laws that will prevent the exposure of records of such review committees.

“(5) At present, the SAMA Chapter at the Medical College of Georgia and Emory University School of Medicine each send one ex-officio member to the Medical Association of Georgia’s House of Delegates. To increase the mode and depth of involvement of the medical students of our state in MAG, it is recommended that these delegates be granted full voting membership in the House of Delegates, with the privilege of serving on committees, proposing resolutions, and in all other rights and privileges.

“Additionally, the Task Force on Medical Schools of the Subcommittee on Medical Education proposes that each of the SAMA Chapters of the Emory and Medical College of Georgia schools of medicine be allowed to select four delegates from their memberships to send to the MAG House of Delegates meetings. These eight delegates representing the two SAMA Chapters should be granted full voting delegate membership, including the privileges of serving on committees, voting, and all other rights and privileges of MAG delegate members.”

It has been my pleasure to serve this House as Chairman of this important Committee of the Association.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends disapproval of recommendation (1) contained in lines 3 through 14 and recommends instead the following: “The concept of decentralization of medical education, which includes medical students, paramedical education, and continuing education of physicians is to be encouraged. The resources of the medical schools, hospitals and other facilities of this State must be developed in concert with the practicing physicians for these purposes. MAG encourages county medical societies to work with these groups to develop such ‘satellite centers of medical education.’ This function should include: (a) that there be local option on the part of the county medical society, both in approving entry into such an association with the medical school and in requesting termination of such an association; (b) that the educational program should be an areawide effort, involving in some way all of the hospitals in the area which agree to participate, and must not be confined to any single institution.”

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Education.

RECOMMENDATION 2—Your reference committee recommends approval of Recommendation (2) contained in lines 15 through 25 and additionally rec-

ommends that this be referred to the MAG Committee on Education for implementation.

HOUSE OF DELEGATES ACTION—Delegate Menard Ihnen of Augusta moved that recommendation 2 of the report of the Committee on Education be amended on line 19 with the inclusion after the word “education” of a parenthetical phrase “which do not include programs of medical schools.” The House adopted this portion of the reference committee report as amended.

RECOMMENDATION 3—Your reference committee recommends disapproval of Recommendation (3) contained in lines 26 through 32.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the reference committee.

RECOMMENDATION 4—Your reference committee recommends approval of Recommendation (4) with these changes. In lines 35 and 36 delete the words “concerning the State Board of Medical Examiners, giving that board disciplinary power,” and insert in line 35 after “Georgia” and before the “for” in line 36 the words “in order to provide adequate and effective self disciplinary procedures” and in line 38 the deletion of the word “physicians” and insertion of the word “practitioners” so that the recommendation would read “the Medical Association of Georgia should urge the State Legislature to amend the laws of Georgia in order to provide adequate and effective self-disciplinary procedures for the protection of the general public and the medical profession from incompetent, dishonest and/or otherwise unfit practitioners. Further, MAG should encourage legislation that will provide immunity from litigation to physicians who serve on review committees regarding information discovered in these reviews and laws that will prevent the exposure of records of such review committees.”

HOUSE OF DELEGATES ACTION—Adopted this portion of the Reference Committee report.

RECOMMENDATION 5—Your reference committee recommends the approval of Recommendation (5) with the amendment that lines 16 through 26 be deleted.

HOUSE OF DELEGATES ACTION—Delegate F. William Dowda moved to refer Recommendation 5 to the Committee on Long Range Planning. This motion was adopted by the House. Chairman Whitworth then recommended that the members of the Committee on Education be commended for their diligent work and the obvious efforts that were made by them during the year, as reflected in their report.

Councilors of Medical Association of Atlanta

FLEMING L. JOLLEY, M.D.,
J. HAROLD HARRISON, M.D., and
JOHN T. GODWIN, M.D.

During the past year the Fulton County Medical Society became the Medical Association of Atlanta. The Society altered its governing representation into districts providing representative members to the Board of Directors.

Council meetings have been attended and represented by its Councilors and Vice-Councilors.

Over the past several years interest in continuing education for the practicing physician and the need

for such has been alluded to in many areas of organized medicine.

Various self-examination procedures have been developed in the framework of medical and surgical societies. State medical organizations are accepting continuing education programs as requirements for membership. Improvement in total delivery of health care is the benefit of such a program.

With the increased movement of patients a distinct problem occurs relative to the prescription of medications. Too often lack of identification of the medicine on the bottle is a problem.

The need for proper labeling of each prescribed medication is evident.

RECOMMENDATIONS

(1) Previous deliberations by the House of Delegates on continuing education should be reviewed. It is recommended that the House of Delegates by necessary action required, provide that membership in the organization require an acceptable continuing education program.

(2) That the House of Delegates approve and instruct the Legislative Committee to seek introduction and active support of necessary legislation in the General Assembly for labeling (identification) of all medicines rendered to patients.

FIFTH DISTRICT MEMBERSHIP

Counties and Secretaries	MAG	Members December 31, 1970	Members December 31, 1971
		AMA Dues Paying Only	AMA Dues Paying Only
Fulton			
William L. McDougall			
Atlanta	1,175	960	1,209 959

REFERENCE COMMITTEE RECOMMENDATION
—The reference committee recommends disapproval of Recommendation (1) and Recommendation (2) with the following substitution for Recommendation (2). “The House of Delegates recognizes that in our currently mobile society there exists a need for medication labeling. We feel that this can better be accomplished through education rather than through legislation; therefore, we direct Council to establish a program of information directed to all physicians and pharmacists concerning this need for the labeling of medications.”

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee.

Georgia Medical Care Foundation

F. W. DOWDA, M.D.

In my President-Elect’s message at the time of the Annual Session, I will outline the Foundation’s activities more in full and this will be distributed to you. I would, however, say that the Foundation in essence is the health care delivery arm of the physicians of organized medicine in the State of Georgia and that its primary thrust is to assure medical care with acceptable accessibility and acceptable quality, and that this medical care should be delivered at a reasonable cost.

It is the latter upon which I would like to dwell for a moment with you, in that ordinarily when we think of reasonable costs we think of reducing physician and hospital charges. It has become apparent to

me, however, that the physicians of my State indeed are underpaid for the services which they render, that they often charge too little for office visits, too little for examinations, too little for hospital care and that in order to make an adequate income, which most of them do, they must work long and arduous hours far and above greater than that expected by any other profession. One of the aims of the Foundation this year is to reduce some of these inequities and we will continue to fight for you in this direction as long as I am associated with and have anything to do with the Foundation.

I feel very strongly about two points, however. If doctors are going to remain free, they must learn to stand strong and stand firm and stand together or I will guarantee you that you will end up being a salaried servant of the Government. While standing strong and standing firm we must, as doctors, continue to provide what we have done since the turn of the century and that is the best care to our patients that is obtainable anywhere in the world.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee recommends approval of this report with the addition of the following recommendations: (1) That the Foundation should be commended for its accomplishments during its youth and should be urged to improve its operations and procedures as quickly as possible. (2) Notification of and invitation to Foundation Board meetings should be sent at least 10 days prior to Board meetings to local medical society leaders and medical society executives. (3) The appeals procedure should be explained in each instance when a provider’s claim is rejected or denied.

While we wish to commend the Foundation on its communication efforts to date, we would recommend the following:

(4) (a) That the Foundation information in the *Journal of the Medical Association of Georgia* always be prominently identified by a notation on the cover of the MAG *Journal*. (b) That the county medical societies be encouraged to invite Foundation Board members to attend and explain the Foundation activities at their meetings.

(5) A detailed activities report should be submitted by the Foundation Board of Directors to the Annual Session of the MAG House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Care Foundation, Inc. with the additional recommendations made by the Reference Committee.

Resolution 72-3

Dissociation of Medical Association of Georgia from Georgia Medical Care Foundation, Inc.

M. A. GLUCKSMAN, M.D.

WHEREAS, the Medical Association of Georgia did, by action of its Council, on September 19, 1970, approve the formation of the Georgia Medical Care Foundation, Inc., for, among other purposes, the objective of maintaining “local control of utilization through peer review”; and

WHEREAS, the said Council did, on October 11, 1970 approve the Articles of Incorporation of said Foundation; and

WHEREAS, the said Council did, on December 12, 1970 approve the Bylaws of said Foundation; and

WHEREAS, neither the said Articles of Incorporation nor the said Bylaws provide for the Foundation's acting as the agent of any third party, governmental or otherwise; and

WHEREAS, in its actual function said Foundation has acted primarily as the agent of such third parties to the great detriment of the members of this Association and of the hospitals in which they practice; NOW, THEREFORE, BE IT

RESOLVED, that the Medical Association of Georgia disassociate itself as promptly and completely as possible from any and all connection with the said Georgia Medical Care Foundation, Inc.; AND BE IT FURTHER

RESOLVED, that if there exist contractual relationships of fixed term between said Association and said Foundation, such contracts shall not, upon expiration of their present term, be renewed; AND BE IT FURTHER

RESOLVED, that the Association take such action as may be necessary promptly to collect from said Foundation all monies owing it; AND BE IT FURTHER

RESOLVED, that no employee of the said Association shall perform any function whatever for the said Foundation during any period in which said employee's salary or wage is being paid by the Association; AND BE IT FURTHER

RESOLVED, that the Officers of the Medical Association of Georgia be, and are hereby, directed to execute the above resolutions forthwith.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends disapproval of this resolution since it feels that if the recommendations in the foregoing Georgia Medical Care Foundation Report are implemented then they will serve to improve the relations between the Foundation and the county medical societies.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee.

Speaker of the House of Delegates

HARRISON L. ROGERS, M.D.

I am pleased to report that our House of Delegates is in a position to operate very efficiently this year. With approval of the House, again this year those reports not containing recommendations will be presented to the Delegates at the first session of the House for their acceptance. As directed, if referral is desired by any Delegate, particular reports will be referred to reference committees for evaluation.

As directed by the Delegates in 1971, a committee was appointed to consider the MAG budget and methods of financing it. This committee has been named "Reference Committee F" and has met prior to the Annual Session for consideration of the budget. It is hoped that this group will be able to make recommendations which the House will find acceptable.

Once again your present and past Speakers attended in your behalf the Southeastern Speakers Conference in New Orleans. The efforts of our neighboring

states in many areas were reviewed, especially in the fields of county, state and national Medical Association membership and recommendations will be presented.

This year for the first time a Delegates' Informational Handbook has been provided each of you. This Handbook contains the pertinent parts of our Constitution and Bylaws as they relate to the actions of the House of Delegates. In addition, for the benefit of new Delegates, a simple guide to parliamentary procedure for use in consideration of business before the House is provided.

RECOMMENDATIONS

(1) That the Reference Committee seek an evaluation of the new Handbook by the Delegates with their suggestions for additions or deletions.

(2) That MAG institute a yearly day-long seminar on the "Socio-Economics" of medical practice for the students, interns, residents, and their wives in Atlanta and Augusta with a view to bringing this group closer to organized medicine as they go out into practice.

REFERENCE COMMITTEE RECOMMENDATION
—The reference committee recommends approval with commendation of this report. The committee recommends the following substitution for Recommendation (1): "That the Procedural Handbook for Delegates be made a permanent part of the Delegates' Handbook." The reference committee recommends approval of Recommendation (2) with the insertion of the words "in Atlanta and Augusta" between the words "institute" and "a" in line 4, and the addition of the sentence, "The similar program of the Louisiana State Medical Society was noted and is recommended for guidance to Council," in line 8 after the period.

HOUSE OF DELEGATES ACTION—Adopted the report of the Speaker as amended by the reference committee, and with the additional recommendations made by the reference committee.

President-Elect

F. W. DOWDA, M.D.

At the time of the Session of the House of Delegates I shall try to present to you my full program as President for the year. I have, as President-Elect, attended all of the Council and Executive Committee meetings and all of the AMA meetings that have occurred during the year as well as innumerable other places where I have gone to talk and explain our Association and its many operating functions. The Medical Association of Georgia is growing by leaps and bounds.

RECOMMENDATION

It is my firm opinion that all of the activities of the Medical Association, the activities of CHAMPUS, the activities of the Foundation, the routine activities of the Association, the Regional Medical Program, and EMCRO require and demand that indeed we obtain a medical director, that is, a director who is a physician himself—to coordinate all of these activities. We now have a coordinator for the Regional Medical Program and my thought would be to expand this man's function into a full-time job in order that we

may have the necessary physician input at the top of the Association, where it should be.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends disapproval of the President-Elect's recommendation in its entirety by deletion of lines 9 through 20.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect with the deletions recommended by the reference committee.

Supplemental Report 72-2

Allied Health Subcommittee

JOHN T. GODWIN, M.D., *Chairman*

The Health Careers Council (HCC) of Georgia has been functioning for the past several years in the area of allied health careers recruitment and has been responsible for the Allied Health Careers Clubs of Georgia. At present the Health Careers Council is without financial support and with no expectation of receiving any in the foreseeable future. These two activities of the HCC are most important to our profession and to those interested in health careers. I believe that every effort should be made to continue these activities and that it would be most appropriate for the Medical Association of Georgia through its Allied Health Subcommittee to undertake the support of the AMCC and expand its involvement in health careers recruitment by coordinating its activities with those of other interested agencies—State Department of Education, local school authorities, State Scholarship Commission, State Nurses Association, Georgia Hospital Association and others. This would allow for cooperation in the development of health careers day programs for schools in assisting school counsellors in counselling students interested in health careers and in preparing audio-visual materials on health careers.

RECOMMENDATIONS

(1) MAG take responsibility for the Health Careers Council with the concurrence of its membership, and provide space in the MAG Headquarters Building for records, provide telephone service and on-going continuity for the organization.

(2) In addition, one of the MAG Field Representatives be designated as Secretary of the Health Careers Council.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report and its recommendations with the following amendment, inserting the words "Auxiliary to be asked to" between "MAG" and "take" in line 22 and the insertion of a period after the word "membership" in line 23 and the deletion of the word "and" in line 23 and the deletion of all the words in lines 24 through 28, so that the recommendation would read, "MAG Auxiliary be asked to take the responsibility for the Health Careers Council with the concurrence of its membership."

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report 72-2 as amended by the reference committee.

Supplemental Report 72-4

Experimental Medical Care Review Organization (EMCRO)

GEORGIA MEDICAL CARE FOUNDATION

Beginning in 1956 with the opportunity for MAG to express its desire openly to be a part of the Third Party operation in its state, MAG applied for and received the assignment as carrier for Military Medicare. In the course of that effort it was necessary for MAG to appoint a Fee Negotiating Committee whose responsibility it was to go to Washington, D. C., and negotiate with the Department of Defense on a maximum schedule of allowances which would apply to the CHAMPUS Program in our state.

In later years, approximately 1970, the private health insurance industry came to MAG at that time when they were beginning to market Major Medical coverage, and asked for help in determining the appropriate action on statements received from physicians which, under the Major Medical coverage concept, exceeded the schedules of allowances used historically in the industry. MAG accepted that challenge and requested the Fulton County Medical Society to serve as a pilot study for the review of claims submitted by those carriers. The success of that effort led to the appointment of 14 District and Local Committees under the Committee on Insurance Review.

About 1962 the Committee on Fee Negotiation and the Committee on Insurance Review were combined to form for many years what was known as the Committee on Review and Negotiating which handled all problem claims submitted by any Third Party carrier, any physician provider, or even a patient beneficiary.

In 1970 it was a matter to change the name of the Committee on Review and Negotiating to the Committee on Peer Review to provide that function for all Third Parties and others.

In 1971 Senator Bennett of Utah introduced in Congress the Bennett Amendment to HR-1, the Social Security Amendments Acts of 1971, which would provide for professional standards review organizations (PSRO) for the purpose of reviewing Third Party claims. Contact was made with Senator Herman Talmadge of Georgia, a member of the Senate Finance Committee which has jurisdiction over HR-1 and the Bennett Amendment to express our approval of the concept incorporated in the Bennett Amendment and assure Senator Talmadge that MAG was adequately prepared to provide for the Peer function through its Committee on Peer Review. Senator Talmadge advised MAG that it was the feeling of the Senate Finance Committee that a medical association would not be in a position to serve as a PSRO since it did not represent all physicians.

It was at this point when MAG organized and incorporated the Georgia Medical Care Foundation to provide for an organization which represented all physicians and presented no barriers to associations such as membership dues, or affiliation with a local association. At the same time Dr. Paul Sanazaro's National Center for Health Services Research and Development of the Department of Health, Education and Welfare was advertising for grant applications from organizations to develop experimental medical

care review organizations (EMCRO) for the purpose of developing federally funded experiments in Peer Review. MAG applied for and received one of the four developmental grants for EMCRO, thereby placing MAG in a position of being prepared to provide for Peer Review of physician generated claims by either mechanism determined to be appropriate by the Congress: As a medical association or as an independent foundation. During its eleven month developmental grant, in addition to preparing the operational grant which is now in Washington, D. C., under consideration, the EMCRO has been involved in the following projects:

(1) Assisted in designing the computer system to be utilized by the Georgia Medical Care Foundation in its review of Medicaid claims. The system will be operational by July 1, 1972, and will include a Burroughs 2500 computer with four video display tubes. This computer will draw claims data from the Georgia Department of Health's computers by telephone lines.

(2) Began joint development with representatives of the Georgia Nursing Home Association of a system of centralized utilization review for nursing homes. The system would satisfy the requirements of the Medicaid program for review of all patients in skilled nursing homes, and would review all other patients in nursing homes as well. Review will be conducted in order to determine: 1) if the patient continues to require the level of care provided, and 2) if the care and services rendered by the nursing home are appropriate to the patient's needs. Review would be accomplished centrally—at one location—utilizing electronic data processing techniques to the greatest extent possible.

(3) Conducted two Criteria Development Workshops: one involving the MAG Interspecialty Council, and one in Savannah involving a total of 34 physicians from eight specialty societies. These criteria are intended for use in the Emcro's Hospital Discharge Abstract System, which would be made available to interested hospital medical staffs. The System's computer would match the care reported on the abstracts to the criteria developed by the specialty societies, and relay the results of this matching to the hospital's medical staff.

(4) Began an evaluation of the problem-oriented record as a means of recording medical care provided, and as a means of evaluating the quality of that care. A study of Grady Hospital's use of the problem-oriented record is part of this effort.

RECOMMENDATION

It is recommended by the Board of Directors of the Georgia Medical Care Foundation, Inc., that MAG's House of Delegates endorse the application for an operation grant to manage an Experimental Medical Care Review Organization, and that the appropriate reference committee of the House of Delegates consider in as great detail as necessary the operational grant as presented by MAG Staff to assure the House of Delegates of the appropriateness of this endorsement.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with the following amendment and addition to its recommendation by deletion of lines 21 through 24 and with the addition of the following: "and that (1) MAG obtain in writing from the Na-

tional Center on Health Services Research and Development the agreement that if MAG decides that this Experimental activity is not feasible then MAG's procedures involved in and arriving at that conclusion remain the exclusive property of MAG, (2) before this Experimental activity becomes an operational program, the approval of the MAG House of Delegates must be obtained," so that the recommendation will now read: "It is recommended by the Board of Directors of the Georgia Medical Care Foundation, Inc., that MAG's House of Delegates endorse the application for an operational grant to manage an Experimental Medical Care Review Organization, and that: (1) MAG obtain in writing from the National Center on Health Services Research and Development the agreement that if MAG decides that this Experimental activity is not feasible then MAG's procedures involved in and arriving at that conclusion remain the exclusive property of MAG, (2) before this Experimental activity becomes an operational program, the approval of the MAG House of Delegates must be obtained."

HOUSE OF DELEGATES ACTION—Delegate M. A. Glucksman, Brunswick, moved that the report of the reference committee be amended by deleting the phrase "Board of Directors of the Georgia Medical Care Foundation, Inc." as it appears on lines 17 and 18 of the reference committee and insert in lieu thereof the phrase "Executive Committee of Council." This motion was approved by the House of Delegates. Delegate F. William Dowda, Atlanta, moved that the report of the reference committee be amended by striking the word "operational" as it appears on line 19 of the reference committee report and substituting in lieu thereof the word "experimental." The House of Delegates adopted this amendment to the reference committee report. The House then adopted the report of the Reference Committee as amended.

Chairman Whitworth then thanked the members of his reference committee for their time and effort and moved that the report of Reference Committee C be adopted as amended. This motion was duly seconded and approved.

Delegate Louis Felder was recognized for the purpose of presenting for information, a resolution which he stated to be of a far reaching nature. Dr. Felder advised that Resolution 72-10 had been distributed to the members of the House of Delegates. Speaker Rogers reminded Dr. Felder that Resolutions could be placed before the House on the last day of the Session pursuant to unanimous consent only. The Speaker then recognized Delegate F. William Dowda who requested that the matter of Dr. Felder's resolution be temporarily put aside and that unanimous consent could be requested following presentation of the final Reference Committee report. This was agreeable to Dr. Felder and the Chair.

Report of Reference Committee D

W. E. Barron, M.D., *Chairman*

Chairman Barron reported to the House that the reports and resolutions referred to Reference Com-



Reference Committee C hears testimony pertaining to the items on its agenda.

mittee D had been considered by the Committee which met at 9:00 a.m., in the Magnolia Room, Macon Hilton Hotel, Macon, Georgia, on May 13, 1972. Members of the Committee present included: W. E. Barron, M.D., Newnan, Chairman; Samuel M. Goodrich, M.D., Milledgeville, Vice Chairman; Peter Lampros, M.D., Toccoa; C. D. Hollis, Jr., M.D., Albany; Armand M. Hendee, M.D., Atlanta and Jack Lawler, M.D., Columbus.

President

W. C. MITCHELL, M.D.

The job of being President of the Medical Association of Georgia is an honor, but I'm sure those of my predecessors who have served in this capacity will bear me out when I say that there are unknown built-in obligations and responsibilities that go with this office.

It has been time consuming, but a distinct pleasure representing the Association as its head man in these past months: As a member of the Georgia Delegation to the AMA conventions, as a member of the Foundation, and as ex-officio member of all the Committees, serving on the Search Committee for replacement of the President of the Medical College of Georgia, on the Student Selection Committee for Emory Medical Students, as a member of the Georgia Medical Education Committee, presiding at monthly Executive Committee meetings, attending quarterly meetings of the Council, chairing the annual Committee Conclave and the Leadership Conference, meeting with the Woman's Auxiliary, and the numerous speaking engagements both to medical and allied medical groups.

To say that this has been a year of challenge would be putting it very mildly, and had it not been for our excellent and hard working committees that have assumed responsibility for guiding their particular part of the program, it would have been impossible, and to the hard working committee chairmen, I will be forever grateful.

It goes without saying that both my job and the committee chairmen's jobs have been aided greatly and would have probably been insurmountable without the efficient and hard work of our excellent house staff, so ably headed by the Executive Director, Mr. Ed Smith.

Several things that have occurred during the year are worthy of special mention. The implementation of the increase in dues, as directed by the House of Delegates; the excellent work of the legislative committee that was headed by Dr. Harrison Rogers that fought so gallantly to carry out the MAG policy of a separate Board of Health as opposed to it being a part of the Department of Human Resources; the successful work of the Georgia Medical Care Foundation; the division of the state into north and south districts, with the addition of a second field man to cover one of these districts; and the continued efficient work of the government programs that are supervised and housed in the headquarters building.

RECOMMENDATIONS

(1) We should continue to face the issues that are ahead of us and maintain mature leadership in our ever continuing fight against the gradual encroaching socialization.

(2) We should continue our efforts to help our legislators plan for the best health care possible for our state and nation.

(3) Continue our support to GaMPAC and AMPAC.

(4) Render all aid possible to our own Woman's Auxiliary.

(5) Continue to support and strengthen the Georgia Medical Care Foundation.

(6) Encourage better communication with all our membership, and to urge each and every one of our nearly 4000 members to get more involved and to really be a part of the organization.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the President as recommended by the reference committee.

Second Vice-President

BRASWELL E. COLLINS, M.D.

Your Second Vice-President attended Executive Committee and Council Meetings throughout the year.

RECOMMENDATIONS

(1) My recommendation is that the name of the MAG Annual Leaders and New Members Conference be changed. This meeting is too good to be so restricted. Many members, perhaps through modesty, do not want to pose as leaders. They also know they were new members many moons ago. All MAG members should be encouraged to come. The meeting should be called something like the MAG "Know-It-All" or "Learn-It-All" Annual Conference.

REFERENCE COMMITTEE RECOMMENDATION

—The reference committee would like to approve this report, with the recommendation that the name of the annual County Society Officers and New Members Conference be changed to "MAGNET." The letters in the name would be an acronym standing for "Medical Association of Georgia New Educational Training." We would further recommend that an open invitation be extended to all MAG members to attend this conference, with special encouragement to new members and officers. We also suggest that the Committee on Communications seriously consider changing the date of this conference to a date more beneficial to the newly elected county society officers.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second Vice President with the amendments and additional recommendations made by the reference committee.

Emergency Medical Service Committee

CARL JELENKO, III, M.D., *Chairman*

The Committee on Emergency Medical Services of the Medical Association of Georgia met at MAG Headquarters in 1971 on January 9, April 3, July 9, August 7, and December 11.

The Committee concerned itself with several areas:

(1) **LEGISLATION:** Including the Ambulance Statute, the Medical Advisory Board Bill, and the Visual Acuity Bill.

(2) Preparation of a Mass Casualty Manual.

(3) Governor's Commission on Emergency Medical Preparedness.

(4) An emergency medical system for south central Georgia.

(5) Emergency Medical Technicians training.

(6) Hospital signs.

(7) Ambulance and emergency room categorization.

(8) Emergency ambulance communications.

(9) Television spot commercial to combat traffic deaths.

The Committee made significant progress in several of the aforementioned areas during 1971, but considerable effort continues to be required in some of the areas listed.

(1) An intensive campaign including personal contact, circularization, publication of editorials, and testimony failed to persuade the Legislature to enact the Ambulance Statute during the Legislative Assembly in 1971. The Bill was returned to Committee. It appeared that an important parameter that had not been sufficiently emphasized was the economic impact of failure to enact this Statute. Accordingly, the Committee mounted a vigorous campaign in the latter part

of 1971, contacting the legislators directly and through MAG Doctors of the Day and physicians in various communities throughout Georgia. The emphasis of these contacts was that failure to enact the Ambulance Statute would result in a ten per cent decrease in funds from the Federal Highway Administration to the State of Georgia. Further, approximately 1.2 million dollars has been defined and was available through the Georgia State Department of Health for ambulance purchase and training of Emergency Medical Technicians.

Renewed effort was made during the year to emphasize the need for passage of the Visual Acuity and Medical Advisory Board Bill. Emphasis with regard to the former pointed out that approximately 300 Georgia drivers currently hold valid driver's licenses although they are legally blind! With regard to the latter Bill a major problem appeared to concern the composition of the Board. This Bill had been passed by previous legislature but had been vetoed by the former Governor. It was the thrust of the Committee's emphasis that it be re-enacted with the hope that the current Governor would sign it into law.

(2) Through the dedicated work of Dr. Virgil Williams of Griffin, many of the manuals and procedures for the management of mass casualties in disaster situations were reviewed for the preparation of a Mass Casualty Manual. It was the intent of the Committee to prepare a generic, concise statement of the basic principles for disaster planning suitable for use by a hospital of virtually any size and configuration in Georgia. Such a Mass Casualty/Disaster Plan was drawn up and published broadly. The Plan was endorsed and co-sponsored by the Georgia State Committee on Trauma of the American College of Surgeons and by the Disaster Planning Committee of the Georgia Hospital Association. The Georgia Hospital Association distributed the Plan to all administrators and chiefs of staff in the various hospitals throughout Georgia. In addition, the Plan was published as follows:

(a) The Mass Casualty/Disaster Plan: Some Basic Concepts. *Bulletin of the American College of Surgeons*, 56:16, November, 1971.

(b) The Mass Casualty Plan: Some Basic Concepts. *JMA Georgia*, 60:364, November, 1971. To date approximately 300 requests for reprints have been received by the Committee.

(3) In April 1971, the EMS Committee recommended to the Governor that he establish a Commission on Emergency Medical Preparedness. Accordingly, a resolution was enacted by the Committee endorsing this concept and presented in person to the Governor. The resolution was reviewed by the Departments of Highway Safety, Civil Defense and Health, and on September 27, 1971, by Executive Order, the Governor's Study Commission on Emergency Medical Services was established. The Commission comprised 10 individuals representing various disciplines concerned with emergency care and included as consultants a member of the combined Board of Medical Examiners and the Chairman of the Legislative Committee of MAG. The Governor's Commission embraced the MAG, Georgia Hospital Association, Georgia Municipal Association, Independent Insurance Underwriters of Georgia, Georgia Association of County Commissioners, Georgia Department of Public Health, Department of Planning and Community Affairs, Georgia

Safety Council, the Georgia Bar Association, and representatives from the House of Representatives and the Senate of the State of Georgia. A Summary Report of the Commission's findings was accepted by the Governor and is in process of being developed into appropriate legislation. Further, the Commission recommended, and the Georgia Department of Public Health adopted as policy, a position regarding emergency communications and minimal standards for Emergency Departments. These will be discussed later in this report.

(4) The Committee considered in detail a project under current investigation by Georgia Regional Medical Programs submitted from an 11-county area in south central Georgia comprising an Emergency Medical Services network for the area. The program comprises purchase of ambulances and equipment; training of technicians; and the establishment of central and primary emergency care facilities in various of the area hospitals. Included also was a cooperative air evacuation system using the facilities of Moody Air Force Base. This project was recommended highly for implementation; and support for it was expressed to Regional Medical Programs. The project was made the priority item for fiscal 1971 by GRMP; was funded, and is currently operative.

(5) Considerable need was perceived to train the Emergency Medical Technicians. It was recognized that several courses were being offered in various areas of the State in an attempt to accomplish this need. The Georgia Department of Public Health proposed establishing a series of 12-week courses in area technical schools to be conducted using as a text the American Academy of Orthopaedic Surgeons course: "Emergency Care and Transportation of the Sick and Injured." This was highly endorsed by the Committee; and the Committee joined the Committee on Trauma for Georgia of the American College of Surgeons in offering the services of physician personnel to help in teaching and examining students. Funding was made available for the establishment of these courses which began in the summer of 1971. The first course was conducted at the DeKalb Technical School and graduates were given the examination of the Registry for Emergency Medical Technicians-Ambulance at the completion of the course. These courses will be established in technical schools throughout the state so that, in most instances, an individual will have to travel less than 50 miles from his home to attend these schools. Further, the courses will be supplied free, being funded by the Department of Health. Courses are offered at night and will not interfere with an individual's regular employment. The only requirement for enrollment is the possession of an active Standard and Advanced First-Aid certificate. To provide a method for obtaining these certificates, upgrading of a course in Immediate Care of the Sick and Injured at the Medical College of Georgia was supported by the Committee. This course currently comprises four days (24 hours) work at the completion of which the successful candidate obtains a Standard and Advanced First-Aid certificate. The MCG course is currently offered twice yearly.

(6) Hospital signs to direct the traveler through Georgia to hospitals possessing emergency facilities capable of attending their needs were perceived by the Committee as a real and urgent need in Georgia. The

EMS Committee joined with several agencies including the ACS Committee on Trauma, the Department of Health, and the Georgia Hospital Association in working toward obtaining placement of these signs on Georgia's highways. Major efforts were expended by the Georgia Hospital Association in this regard. It appeared that certain Federal and Department of Highway Safety regulations required modification such that the highway signing could be accomplished. Through diligent effort, this was accomplished, and the Department of Highway Safety is currently in the process of placing a standard marker on State and Interstate Highways to indicate the location of those hospitals possessing emergency rooms staffed round the clock with at least an on-call roster of physicians who will respond within five minutes of a call. The sign comprises the white letter "H" on a dark blue background below which is the word "Hospital" and an arrow, also in white. The signs are of reflective material and are those acceptable to the Federal Department of Highways.

(7) Several studies of the status of Emergency Medical Services were conducted and considered by the Committee during the year. These included a study of the categorization of Emergency Departments, and the status of Ambulance Services in Georgia. It was determined that the accidental death rate in rural Georgia for injured individuals was almost 700 times greater than that for injured individuals in urban Georgia! Accordingly, the Committee investigated ways that Emergency Departments and Ambulance Services could be improved. The Department of Public Health defined approximately 1.2 million dollars which would be available in 1972 for Emergency Medical Technician training and for ambulance purchase. These facts were made available to legislators. Further, the Department of Health altered its regulations to require that all hospitals, unless specifically exempted, maintain an emergency room. Further, the regulation details the minimal equipment which must be available in each Emergency Department.

(8) Communications between hospitals and ambulances and between hospitals was perceived to be an important part of any emergency medical system. During the year, the Federal Communications Commission requested that the State indicate its preference of communications frequencies for emergency purposes. Accordingly, the Committee supported the findings of a Subcommittee on Communications of the Governor's Commission recommending standardization of equipment, maintenance of short-wave radio equipment in all hospitals and ambulances; and development of State funds to assist hospitals and ambulance operators to carry out these recommendations.

(9) Because of the inordinate mortality from vehicular accidents in Georgia—which exceeds by far the National average—the Committee discussed a variety of attacks at the problem. It was proposed that a television commercial message be prepared to be shown as a public service on the State's television stations which could serve to sensitize the driver population to the risks of automobile operation. The Committee voted to support this approach with funds if necessary; and the Governor made sufficient monies available for the production of a thirty-second commercial message, "the pilot" of which is in current production. This message will comprise a listing of the

names of those individuals recently killed in automobile accidents on Georgia's highways and the message will be kept fresh at frequent intervals.

Future efforts of the Committee will include continued efforts at obtaining appropriate legislation to forward Georgia's preparedness for delivering emergency medical services; supporting and establishing emergency medical systems in various areas throughout the State; developing methods for improving Emergency Departments and assisting in the training of Emergency Medical Technicians; and evaluating and forwarding the various projects underway.

RECOMMENDATIONS

Resolution

SUBJECT: MEDICAL ADVISORY BILL

WHEREAS, the MAG Emergency Medical Services Committee and MAG is interested in continually promoting traffic safety and needed legislation to support traffic safety,

WHEREAS, H.B. 58 Re-Examination, passed by the 1972 General Assembly, requires all drivers to have their eyes examined every four years,

WHEREAS, physicians feel that medical reasons for driver limitation should be determined by physicians; THEREFORE BE IT

RESOLVED, that MAG support legislation to set up a board known as the Medical Advisory Board, to assist the Department of Public Safety in determining the medical fitness of drivers with certain diseases or limitations.

Resolution

SUBJECT: BURNS CENTER

WHEREAS, the MAG has supported the efforts to establish a statewide Burns Center located at the Medical College of Georgia,

WHEREAS, there is a continuing need for such a Burns Center in order to take care of additional patients and conduct research in this area; THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia support the efforts to establish a Burns Center at the Medical College of Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—After much discussion regarding the propinquity of televising the names of traffic victims so soon after death, as proposed on page 6, lines 4-18 of this report, the reference committee feels that this should be done only after permission has been secured from the family of the deceased. We would therefore like to amend the report by placing on page 6, line 17, a comma after the word "highways" and adding the words, "after permission has been secured from the families."

In regards to the Resolution on the Medical Advisory Bill (page 6, lines 29-36 and page 7, lines 1-7), your reference committee heard much discussion as to the difficulties in getting such a bill passed through the legislature. The committee feels that such efforts should be continued, and gives its support to this endeavor.

The reference committee also gives its support to the Resolution on Burns Center, recorded on page 7, lines 8-18.



Mrs. Catherine Wooten, Assistant Director of MAG and Dr. Preston Ellington congratulate each other on the success of MAG's 118th Annual Session.

HOUSE OF DELEGATES ACTION—Delegate Wytch Stubbs, Decatur, moved that the MAG support the efforts to establish a burns center at a location to be determined by the Emergency Medical Services Committee. This motion was defeated by the House, and the report of the committee was adopted.

Cancer Committee

HOKE WAMMOCK, M.D., *Chairman*

The year 1971-1972 for the Committee on Cancer has been perhaps the most active and productive year in the history of the Cancer Committee.

The Committee on Cancer has been responsible for co-ordinating the Cancer Control Program in Georgia seeking the joint participation of all agencies concerned with Cancer Control; namely, the Georgia Regional Medical Program, the American Cancer Society, State Public Health Department, Cancer Control Section, and other agencies concerned with cancer.

GEORGIA REGIONAL MEDICAL PROGRAM

For the past three years the Georgia Regional Medical Program has been Project Director for Cancer in Georgia. Because of a cutback in funds, the Regional Medical Program requested that the Cancer Committee assume the responsibility for the operation of the following ongoing projects:

1. Project # 13, which included: (a) Area Cancer Facilities, now 12 in number; (b) Cancer Workshop (Symposia or continuation of educational programs on various cancer topics); (c) Tumor Registries.
2. Project # 30, the Augusta Radiation Therapy Center, the Committee on Cancer to act in an advisory capacity for the operation of this project.

The Committee accepted the request of the Regional Medical Program and signed an agreement between the Regional Medical Program and the Committee on Cancer of the Medical Association of Georgia

for the operation of these Projects. The Committee then requested the participation of the Georgia Division of the American Cancer Society and they agreed to participate in the professional education phase of the Program. The responsibility for fiscal management will remain a function of the Georgia Regional Medical Program, with programmatic responsibilities being those of the MAG Cancer Committee.

SUBCOMMITTEES

In order for the Committee on Cancer to operate in a more efficient manner, we subdivided the Committee into Subcommittees with a chairman each as follows thus forming an Executive Committee:

1. Tumor Registries.
2. Area Cancer Facility Workshops.
3. Area Cancer Facility Planning & Development (Augusta Radiation Therapy Center).

TUMOR REGISTRIES

In view of the restrictions of the funds of the Regional Medical Program, the support of the Tumor Registries had to be withdrawn, and this meant that Tumor Registries would have to seek support elsewhere. I am happy to report that a number of these Registries are continuing in operation despite the withdrawal of funds. Some have had to curtail their activities, but we hope that this will be corrected.

The Subcommittee on Tumor Registries of the Committee on Cancer has been revising the protocols which have been simplified to some degree, the tabulating of the information on each patient recorded in the Tumor Registry for the purpose of providing information to the computer that is now under operation at Emory University. We are endeavoring to simplify the abstracting of the information from the patient's record in order that we can get a more rapid feedback to the physician on cases registered in their respective clinics.

CANCER WORKSHOPS

The Subcommittee on Cancer Workshops developed the following Programs:

1. Nuclear Medicine Workshop, February 10-11, 1972, Emory University Clinic, Atlanta, Georgia.
2. Advanced Mammary Cancer Workshop, March 8, 1972, St. Joseph's Infirmary, Atlanta, Georgia.
3. Chemotherapy of Solid Tumors Workshop, April 28-29, 1972, Callaway Gardens, Pine Mountain, Georgia.
4. Current Concepts in the Diagnosis and Treatment of Head and Neck Cancer, June 9-10, 1972, at the Medical College of Georgia, Augusta, Georgia.

We feel that these ongoing continuing education programs are of great benefit in disseminating information to physicians of the Medical Association on various subjects in Cancer Control.

AREA CANCER FACILITIES

In the further development of the Area Cancer Facilities, a program has been outlined whereby all Area Cancer Facilities will be visited during the year to determine if they are meeting the standards to qualify as an Area Cancer Facility. Several Facilities have already been visited and others are planned. Up to this

moment, we feel that valuable information has been gained through these visits and will be of great help to us in the future in improving the Programs of the Area Facilities.

It had been our plan to expand the number of Area Cancer Facilities in the State, but due to reduction in funds of the Regional Medical Program, this could not be done at this time. We are hopeful that we will have increase in funds in order that we may lend increased support to the present ongoing Area Cancer Facilities and add additional facilities in the future.

AREA CANCER FACILITY PLANNING & DEVELOPMENT (AUGUSTA RADIATION THERAPY CENTER)

Some four years ago, plans were begun to develop a central radiation therapy center in Augusta. The purpose of this center was to seek cooperation and the participation of all hospitals in the Medical College in developing a radiation center. The Georgia Regional Medical Program has given financial support to this plan and the Committee on Cancer of the Medical Association of Georgia has given its approval for the development of a radiation therapy Center. The centralization of radiation therapy for the Augusta area has many advantages, not only from the standpoint of centralization of radiation therapy but in the field of teaching and research.

DIAL ACCESS SYSTEM

The Committee has had under advisement the question of a Dial Access System of direct communication with some of the out-of-state cancer centers for the purpose of requesting information on the diagnosis and the treatment of a particular type of cancer. The Committee together with the Professional Education Committee of the Georgia Division of the American Cancer Society reviewed this project in great depth, and it was determined that the cost would be too great for participation and that perhaps we could readily obtain the necessary information from our own medical schools in Georgia and from other cancer centers. It was brought out that the Directors of the Area Cancer Facilities are in communication from time to time by telephone or follow-up report to the referring physicians on different phases of cancer, both diagnostic and therapeutic.

THERAPEUTIC RADIOLOGY COMPUTER ASSISTANCE PROGRAM

This matter was reviewed very extensively by the Committee on Cancer as this is a program designed to provide computer assistance to radiologists doing radiation therapy throughout the State. The purpose at this time is to determine and make comparisons in the use of certain types of equipment. The initial phases of this will be undertaken at the Columbus Medical Center, using a smaller, relatively less expensive computer with participating institutions, such as Emory, Macon, Thomasville and Albany. Computerized data is to be obtained from these institutions and compared with the larger unit at Emory and the smaller one that is being installed at the Medical Center in Columbus. It is hoped that this plan of developing computerized techniques will result in more efficient administration of radiation therapy.

STATE BOARD OF HEALTH, CANCER
CONTROL SECTION

The number of applications for state-aid approval is approximately 1,200 for the year 1970 and 1971.

The number of new patients reporting for the first time for treatment for 1970 and 1971 was 980 and 1,044 respectively.

The accrued expenditures for 1970 was \$360,290.07 and for 1971 was \$463,067.47.

The average cost per patient was \$172.14 for 1970 and \$195.80 for 1971.

In reviewing the overall picture, there has been a slight increase in the number of applicants received and number of new patients reporting for the first time, a definite increase in the accrued expenditures for 1971 and with average cost per patient showing a slight increase. Thus the number of state-aid cancer patients is holding about the same level for the past three years, but with a definite increase in the average cost per patient.

AMERICAN MEDICAL ASSOCIATION
CANCER COMMITTEE

A 10-member Advisory Committee on Cancer has been named by the American Medical Association's Board of Trustees.

Kenneth C. Sawyer, M.D., of Denver, an American Medical Association trustee, was named chairman.

The committee is charged with advising the Board on substantial and promising developments in cancer research that warrant public attention, on activities that the American Medical Association might undertake in professional and public education with respect to cancer, and with the Council on Legislation on the appropriate position that might be taken by the American Medical Association with respect to existing and changing legislation that relates to government support of cancer research, cancer control and therapy, and other cancer programs.

RECOMMENDATIONS

The Committee on Cancer would like to recommend that the present format developed this year for continuing education be followed for the ensuing years because we feel that this is one of the most productive ways to keep physicians in Georgia informed on the progress of Cancer Control. It is essential that a coordinated Cancer Control Program directed by the Committee on Cancer with the cooperation of other agencies concerned with Cancer Control be maintained. We invite all to give us the benefit of their expertise in their respective fields in developing a more aggressive program in Cancer Control.

The Chairman of the Committee on Cancer wishes to express his appreciation to all the members of the Committee, the Georgia Regional Medical Program, the Georgia Division of the American Cancer Society, and to the officers of the Medical Association of Georgia and others for their cooperation and assistance in Cancer Control in Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves this report with commendation. It is the opinion of this reference committee that the Cancer Committee of MAG should be highly commended for the excellent job

they are doing, and close liaison with State officials should be continued as in the past.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Cancer as recommended by the reference committee.

Communications Committee

F. G. ELDRIDGE, M.D., *Chairman*

This Committee was established to encompass several other committees:

(1) MAG Annual County Society Leadership and New Member Indoctrination Conference: This conference was held February 19-20, 1972 and the program was arranged by J. Watts Lipscomb, M.D., Chairman of the MAG Sub-Committee on County Society Officers Conference. The Conference was well attended by enthusiastic physicians and members of the MAG staff and commendation to Dr. Lipscomb should be given for arranging this program.

(2) Tapes: Information has been taped by the President and other members of the Executive Committee as well as Headquarters staff to disseminate information to component Societies. A variety of subjects has been discussed. Our Field Staff has informed the Communications Committee that these tapes have been well received.

RECOMMENDATION

It is recommended the tapes be continued and expanded as necessary to keep the component societies informed of progress and events important to members of the Medical Association of Georgia.

(3) Liaison with News Media

(4) The Communications Committee arranged with the AMA Speakers and Leadership Training Group to set up a Seminar in cooperation with MAG for February 20-21, 1972 immediately following the County Society Officers Leadership Conference. Some 30 members indicated an interest in taking this course; however, only 16 were present and it is felt that this is a result of the selection of a Sunday-Monday conference. It was impossible to arrange a more suitable date due to scheduling with AMA.

RECOMMENDATION

It is recommended that a suitable date be established for the latter part of 1972 or spring of 1973 for a repeat of this seminar with timing such that those individuals desirous of taking the course can be present.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves with commendation the recommendation that the communications tapes be continued and expanded as necessary. In hearings before this committee, it was found that some county societies find it convenient to play these tapes during dinner at their meetings. This might be a satisfactory arrangement for other societies, also. As the tapes cost approximately \$1.00 each to produce and distribute and the number of members that can receive the taped message simultaneously is unlimited, your reference committee feels that this constitutes a valuable means of communication and liaison.

In regard to the Speakers Training Conference mentioned on pages 1 and 2 of this report, it was brought to the attention of this reference committee that this was a most effective way for a physician to have his public speaking techniques analyzed by experts. Reference Committee D feels that such a course would enable a physician to significantly improve his public image, and that of medicine in general, and would like to urge as many county society leaders as possible to take this course. We therefore approve with commendation the recommendation recorded on page 2, lines 8-12.

This committee would like to add that it feels such a course should be repeated several times during a year if the response warrants.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee.

Rural Health Committee

IRVING D. HELLENGA, M.D., *Chairman*

The Rural Health Committee of MAG cooperated in the American Medical Association's 24th National Conference on Rural Health, held March 25-26 in Atlanta, Georgia, with the theme "Community Health Programs for Tomorrow." Present were Vernon Wilson, M.D., of HSMHA, HEW, L. J. Snyder, M.D., Chairman of the AMA Council, J. Frank Walker, M.D., Vice Speaker of the AMA House of Delegates, Thomas N. Lumsden, M.D., member of the AMA Council and a number of other professional personnel devoted to the provision of good medical care. This was the first National Conference on Rural Health to be held in Atlanta, and our committee was able to assist materially, at the same time experiencing the fellowship of state Rural Health Committees from throughout the country.

The work of the committee commenced again in August, 1971, at which time a regular meeting was held during the Committee Conclave. Appropriate reports were made to MAG Council and Executive Council at this time.

On August 25-26, 1971, the Seventh Annual Georgia Rural Health Conference sponsored by MAG, the Georgia Farm Bureau Federation and the Cooperative Extension Service, was programmed at the Alpine Lodge in Macon. Participating were Dr. Eugene J. Gillespie, Mr. Jim Ingram, Dr. Addison DuVall, Dr. John Curtis, Judge Curtis Tillman, Rev. James Tiller and Miss Martha Jones. The emphases were on Highway Safety, Emergency Medical Services, Georgia Mental Health, and the Problem of Drug Abuse. This was the largest participation by members of the sponsoring organizations since the inception of a Rural Health Conference, and it was felt that the success of the 1971 meeting would require moving to a larger facility subsequently.

On January 9, 1972, a planning session for the Eighth Annual Georgia Rural Health Conference was scheduled. Present were the Chairman, Dr. Irving Hellinga, Dr. Thomas Lumsden, Dr. E. R. Hensley, Mr. L. P. Whitehead, Nan Prease, Miss Martha Johnson, Mr. Lyndon Beall, and Mr. Carl Bailey. The program for the 1972 Rural Health Conference was scheduled, and will include participation by Representative Virgil Smith, Dean Robert Reynolds, Chairman Harrison L. Rogers, Senator Cyrus M. Chapman, Adron Harden of

the Georgia Farm Bureau, Dr. G. H. Perrow, and winners of the Georgia 4-H Health and Nutrition Awards. The program is scheduled to be moved to the Macon Hilton this year, and will be held August 30-31, 1972.

Plans are underway for the Chairman to attend the National Rural Health Conference in San Francisco, California, on March 16-17, 1972.

RECOMMENDATION

(1) The Chairman would like to recommend that the MAG Rural Health staff representative attend the National Rural Health Conference whenever the Chairman feels it is appropriate.

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee approves this report with commendation.

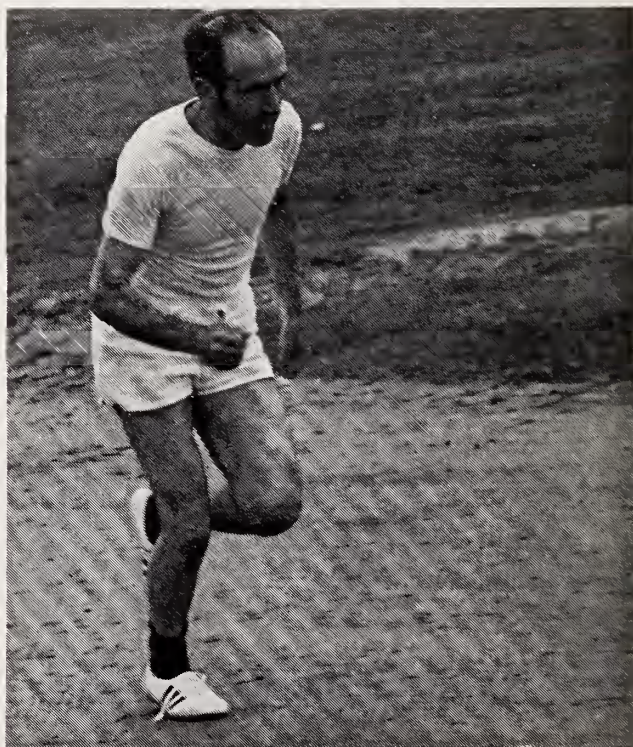
HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Rural Health as recommended by the reference committee.

School Child Health Committee

FRED L. ALLMAN, JR., M.D., *Chairman*

INTRODUCTION

The function of the School Child Health Committee of the Medical Association of Georgia during the past year as in previous years has been to stimulate cooperation by individual physicians and the School Child Health Program to keep the profession informed of the School Health Program and to report to the profession on the progress. Our Committee has worked with the dental association, the public school system, the Health parents groups, Georgia High School Coaches Association and other appropriate organizations during the past year. Specifically, the Committee has accomplished or undertaken the following during the past year.



Richard L. Benson, M.D., of Douglas, Winner of the 4th Annual Medical Mile.

I. FOLLOW-UP ON EXISTING PROJECTS

a. Smoking and Health: The teacher resources kits which were placed in the schools in 1967 in cooperation with the State Department of Education and the Georgia Heart Association, the Georgia Tubercular Association and the Georgia Cancer Society and the State Health Department have continued to be utilized in many schools throughout Georgia and have been used as a model for other states.

b. Post-graduate Course: On August 14, 1971, the Committee again sponsored its annual symposium on the medical aspects of sports. Pat Dyer, head athletic trainer at Georgia Tech, and Don Cooper, M.D., Team Physician for the Oklahoma Aggies, were featured speakers along with Dr. Carl Blyth, Chairman of the Department of Physical Education at the University of North Carolina, and Dr. Royer Collins, Chairman of the Department of Sports Medicine at the Cleveland Clinic. Subjects related to precautions for participation on artificial turf, shoulder injuries in athletics, ergogenic aids for athletics as well as the report of the research project in North Carolina pertaining to the epidemiological aspect of high school sports. The program was well received by all those in attendance. As in the past years, the attendance was better on the part of coaches and trainers than it was on the part of the physicians. School health nurses were invited to the program for the first time and those in attendance seemed to appreciate the invitation and have expressed a desire to be invited to future meetings.

c. News Release in Heat Precautions: A news release was sent to all of the news media throughout the State in August concerning the safe methods of conducting athletic practices and events in hot, humid weather. This item, as in the past, received very good distribution and helped to prevent heat deaths in our State.

d. Pre-School Screening for Vision and Hearing: As approved by the MAG in 1970, a Board has been established which will help to administer the pre-school screening of vision and hearing in our State. The Committee has established an operational mechanism to provide pre-school vision and hearing for all children in the State and further to provide appropriate follow-up medical care for the correction of the defects in vision and hearing which are detected and also to create a vehicle for parent education in eye health as well as to foster local activities in the field of pre-school visual and hearing screening. Lastly, the purpose is to promote research and development of testing methods. The objectives of the pre-school visual and hearing screening are the discovery of children who have visual and auditory defects for which early treatment is imperative and to discover children with serious muscle imbalances and those which need corrective lenses and hearing devices. During Phase I of this program, the facilities and services of the personnel of the Georgia Society for the Prevention of Blindness will be utilized. Phase II calls for the eventual assumption of certain of these responsibilities by a Georgia Society for the Prevention of Deafness to coordinate with the Georgia Society for the Prevention of Blindness in this endeavor. There is no question of the need for this program within our State and the Committee is happy to report that action is being

taken to implement these guidelines and it is anticipated that more and more children will be included in the program each year.

e. Comprehensive Form for Pre-Participation Physical Evaluation of Athletes: A very comprehensive form for pre-participation physical and emotional evaluation of the athletes of our State has been formulated. This should be printed and ready for distribution during summer of 1972 for all schools that would like to utilize the form. Items included on this evaluation are cardiovascular-respiratory fitness, body build, strength tests, measures of flexibility as well as other indications of physical maturation.

f. Round Robin Seminars: The initial seminar to be held in one of the outlying areas within our State will be held in August in Augusta, Georgia. This meeting will be under the auspices of the School Child Health Committee and Chairman of the Program will be Dr. Hamlin Graham, a member of the Committee. It is hoped that through meetings such as this to be conducted throughout the State that parents, coaches, physicians and athletes will be made knowledgeable about the necessary measures that help to maintain health and safety on the athletic field.

II. OLD PROJECTS NOT YET COMPLETED

a. Certification of Coaches: Certification of coaches with minimum standards of instruction in important subjects such as first aid and other preventive measures continues to be an important item on our agenda which should be accomplished in the future. Also under consideration is a criteria for certification of physicians for attendance at athletic events. Neither of these certification procedures have been completely formulated nor have they been submitted to the appropriate organizations as of this time.

b. School Benefit Plan: The Committee continues to feel that there are still far too many youngsters participating in athletics throughout the State who do not have adequate insurance coverage to care for them in case of serious injury. As of this time, however, the Committee is not ready to make a recommendation as to how this defect can be corrected.

c. Nutrition Counseling: The Committee in cooperation with Mrs. Mary Helen Goodloe of the Department of Public Health has undertaken a pilot project on nutrition counseling to be directed toward the overweight, the underweight and those desiring to increase muscle mass. This program is still in the formative stages and it is hoped that action which has been taken in this cooperative effort will be reported next year.

III. NEW PROJECTS

a. Annual Medical Aspects of Sports Program: The Annual Medical Aspects of Sports Program will be held in Atlanta the first week of August, 1972, and as in the past will be held in conjunction with the coaching clinic. This meeting is for physicians, coaches, trainers, physical educators and school health nurses. A direct mailing to all physicians and coaches as well as nurses throughout the State will be made in the next six weeks.

b. Workshop for School Health Personnel: This Committee in cooperation with Dr. Rhodes Haverty, Director of Allied Health Sciences at Georgia State University, and hopefully in cooperation with other

agencies throughout the State and Nation proposes to sponsor a three-day workshop for all personnel that are involved in school health. This would include the physicians, the school health nurses, the psychologists, the social workers, the public health nurses, the physical therapists, the physical educators, the dentists and all other personnel that are called upon to share in the care of school children. It is hoped that this workshop can be held in the Spring of 1973 either in Atlanta or Callaway Gardens.

c. Medical Readings: The School Child Health Committee has subscribed to Medical Readings, Inc. which is based on the screenings and selections from 5,000 medical journals and which supplies timely abstracts of articles that relate to the School Child Health. In addition to a subscription by the Committee, the Committee plans to notify the 190 separate elementary and secondary school districts in this State of Georgia of the availability of this service.

d. Dr. Glenn A. Vergason, chairman of the Department of Special Education, Georgia State University, and Dr. Rhodes Haverty, also of Georgia State University, have suggested that the Committee undertake the preparation of information regarding home and hospital instruction of children who are out of school due to certain illnesses. As of the present time, there are very few guidelines that dictate when children with conditions such as rheumatic fever, infectious hepatitis and infectious mononucleosis be returned and what should be expected of these children once they do return to school, what restrictions and limitations should be given to them. Understandably, this is a sizeable undertaking but it is one which the Committee plans to direct its attention to during the next year.

RECOMMENDATIONS

Professional Standards for Athletic Trainers: This Committee feels that athletic trainers have achieved a status which is worthy of recognition and in this regard would like to recommend that action be taken by the Medical Association of Georgia on professional standards for athletic trainers. We also would like to recommend that a procedure for certification of athletic trainers be adopted with the idea that legislation in these areas may proceed according to appropriate lines.

In concluding, the Committee would like to encourage each member of the Medical Association of Georgia to help develop the integrated relationships of health and education. There can be no question that one needs to be educated in order to develop and protect one's health and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician of Georgia.

REFERENCE COMMITTEE RECOMMENDATION

—The reference committee agrees with the intent of the recommendation on page 5 of this report. However, we have heard testimony to the effect that establishing standards for athletic trainers through legislation might be less than desirable. We would therefore like to encourage the School Child Health Committee to set up standards for athletic trainers that do not require legislation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on School Child Health as amended by the Reference Committee.

Resolution 72-2

Combination of County Society Leadership and New Member Indoctrination Conference with MAG Annual Session

DEKALB COUNTY MEDICAL SOCIETY

WHEREAS, the Medical Association of Georgia's Annual County Society Leadership Congress and New Member Indoctrination Conference is held six weeks following the date that most county society officers assume office, and

WHEREAS, the Conference is poorly attended in relation to the effort put into the preparation and presentation of the meeting; therefore be it

RESOLVED that the MAG Annual County Society Leadership and New Member Indoctrination Conference be combined with the MAG Annual Session, and be it

FURTHER RESOLVED that the county society officers assume office at the MAG meeting in order to coincide with the MAG whose officers assume their position at that time.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee approves the intent of this resolution but, after great controversy in the discussion of this resolution, disapproves the recommendations that the County Society Leadership and New Member Indoctrination Conference be combined with the MAG Annual Session, and that the time county society officers assume office be changed. Your reference committee feels that this meeting should be scheduled for late fall, prior to the new county society officers' installation. We would like to direct the attention of this House to our recommendations regarding the report of the Second Vice President, wherein it was recommended that the name of the conference be changed to "MAGNET," and an invitation to attend be extended to all members of the Medical Association of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report of the reference committee.

Chairman Barron then thanked the members of Reference Committee D for their time and efforts and moved the adoption of the reference committee report as a whole. On motion duly made and seconded, this was adopted by the House of Delegates.

Report of Reference Committee F

John S. Atwater, M.D., Chairman

Chairman Atwater reported to the House of Delegates that the reports and resolutions referred to Reference Committee F had been considered by the Committee which met at 9:00 a.m., in the Azalea Room, Hilton Hotel, Macon, Georgia, on May 13, 1972. Members of the Committee present included: John S. Atwater, M.D., Atlanta, Chair-

man; T. A. Sappington, M.D., Thomaston, Vice Chairman; Charlotte Neuberg, M.D., Macon, James H. Manning, M.D., Marietta and Roger R. Rowell, M.D., Decatur.

Woman's Auxiliary to The Medical Association of Georgia

MRS. GEORGE W. STATHAM, *President*

"Accelerate Awareness into Action" was the theme of the Woman's Auxiliary to the Medical Association of Georgia for 1971-72. County auxiliaries have displayed much enthusiasm in developing this theme within their own communities, with research into needs, and plans for providing those needs with action programs.

To the Medical Association of Georgia and its entire staff, and to Dr. F. G. Eldridge, Chairman of the Advisory Committee, the Auxiliary wishes to express its appreciation for all the help and support it received in achieving the aims and goals for the year.

The State Auxiliary is made up of 37 component county auxiliaries with a membership, as of March 1, 1972, of 2,510 members. The total program included Health Manpower, AMA Education and Research Foundation, Legislation, International Health, Health Education, and Community Health Action Activities.

In the area of Health Manpower, county auxiliaries are active in support of Health Career Clubs, Junior Volunteers, sponsorship of "Tour and See" Days in local hospitals, and Traveling Exhibits set up in schools, banks, and shopping centers. A Health Careers Library, open to interested students, is in its second year of operation. Nursing Scholarships are given by many county auxiliaries.

Because 72 per cent of Georgia's physicians are concentrated in the Metropolitan Atlanta area, and many rural areas are without a single physician, a survey has been undertaken to ascertain the advantages and disadvantages of living in rural areas, and to alert counties as to what they might do to attract physicians.

Assistance and financial aid to WA-SAMA chapters were given to help with their projects. Auxiliaries helped in gathering information on Georgia's medical training centers for the National Housing Information System for interns and residents.

The William R. Dancy, M.D., Student Loan Fund, supported by memorial gifts and contributions, is now worth over \$47,000. Five loans, including three to black students, were made for the year 1971-72.

Contributions to AMA-ERF to help support medical schools and provide a Student Loan Guarantee Fund have an estimated total of \$10,000, with many fund-raising events still to be reported.

The Legislation Committee has been quite active this year, with participation in the Georgia Legislative Forums and Seminars. Focus on GaMPAC, national health insurance proposals, and Medi-Credit program has educated auxiliary members to become more involved in the political arena. (An auxiliary member-at-large has been elected National Democratic Committee Woman for Georgia.)

Support for the ship Hope, adoption of a Greek orphan, the making and shipping of Johnny Coats to a hospital in Ethiopia, the collecting of drug samples

and other medical supplies, entertainment of foreign doctors and their wives, were some of the International Health activities for the year.

Drug Abuse, Safety Hazards, Vision and Hearing Problems and Learning Disabilities have provided fields of concern for many auxiliaries.

One auxiliary is helping to set up and maintain a Drug Abuse Information Center, which is linked by computer to the National Clearing House for Drug Abuse Information in Washington, D. C. This information is available to anyone in Georgia requiring immediate information.

Another auxiliary has placed a Drug Abuse File, containing legal and medical aspects of abuse, in each school library of their county. This auxiliary also arranged a course to teach school counselors, principals and school nurses in how to spot drug use in school.

Operation Dope-Stop is a continuation of a program by one auxiliary to stop the spread of drug abuse. High school students are trained for talks to grammar school students on the subject, "I Don't Use Drugs, And Here's Why."

The Green Safety Lady, created by one auxiliary, is much in evidence in television spots shown during children's shows. Over 35 personal appearances have been made to nursery schools, kindergartens and scout groups.

A talking doll designed to teach safety to children is being developed with the world's largest retailer committed to its distribution. Negotiations with a toy manufacturer are now taking place.

An intensive training course on Medical Self-Help is in its sixth year of operation. To those passing the requirements, Medical Self-Help and First-Aid Certificates are awarded. Security guards from local schools and others are required to take this course. The local Academy for the Blind has requested a course to be taught at their school.

Other outstanding projects encompass Audio and Visual Screening of pre-school children; a Blood Assurance Plan; a Community Health Guide, listing the community's health-related organizations and their services; Cancer Education kits and pamphlets placed in two library bookmobiles that cover seven counties; VD education in high schools; Formation of a Reading Foundation; Physical Fitness Tests; Planned Fat-Low Cholesterol Diet Classes; and a Pap Smear Program for Rural Women.

It is hoped that each doctor who reads this report will congratulate his wife for her part on the team that accelerated awareness into action.

As their President, I wish to commend those concerned members of the Woman's Auxiliary to the Medical Association of Georgia who chose not to become the common thread making up the texture of the cloth, but instead chose to be the purple—"that small and shining part which makes the rest seem fair and beautiful."

RECOMMENDATIONS

The Woman's Auxiliary to the Medical Association of Georgia recommends that:

(1) Auxiliary dues be included in the central billing of physicians by MAG.

(2) County medical societies with membership of 10 or more encourage their wives to organize county auxiliaries.

(3) Pulse Line Editions be addressed and franked at the same time at MAG office to alleviate the transporting of over 2,000 copies to several destinations before the final mailing.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the approval of Recommendation (1) with the addition of the words “when feasible” on line 9, so that the recommendation would read as follows:

“(1) Auxiliary dues be included in the central billing of physicians by MAG when feasible.”

Your committee recommends the approval of Recommendations (2) and (3) indicated in lines 10-15. Your committee commends the Auxiliary and wishes to express their thanks for their great contribution to MAG and beg for their continued support.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman’s Auxiliary to the Medical Association of Georgia as amended by the reference committee.

Woman’s Auxiliary Advisory Committee

F. G. ELDRIDGE, M.D., *Chairman*

As Chairman of the Advisory Committee from MAG to the Woman’s Auxiliary, it has been my pleasure to act in an advisory capacity to the Woman’s Auxiliary through Mrs. Frances Statham, President of the Auxiliary.

Mrs. Statham has attended all of the Council meetings and several other MAG committee groups during her year as President.

Membership in the Auxiliary continues to present a problem; however, the Membership Committee is improving the number of members in the Auxiliary. The Membership Committee is assembling a list of eligible members and every effort is being made to contact these potential members and enroll them in the Auxiliary.

RECOMMENDATION

(1) Last year Dr. S. W. Clark, Jr., made a recommendation that improvement in the billing of Auxiliary dues be accomplished and this was approved by the House of Delegates. I would like to recommend continued effort on the part of MAG staff to accomplish these ends.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman’s Auxiliary Advisory Committee as recommended by the reference committee.

At this point, Chairman Atwater, Treasurer of the Medical Association of Georgia, called upon Dr. T. A. Sappington, Vice Chairman of Reference Committee F, to deliver the report of the committee concerning the Treasurer.

Treasurer

JOHN S. ATWATER, M.D.

It has been the privilege of this Treasurer to serve the Medical Association of Georgia in this capacity for over 10 years, having initially accepted the responsibilities and duties on January 1, 1962. This rep-

resents my final report to the Association as I do not plan to offer for re-election.

Much has transpired through the years. I should like the privilege of recounting a few changes that have taken place. Many more could be detailed.

In May, 1962, the Association had a net worth of \$204,059.46. In the audit completed May 31, 1971, the net worth was \$606,569.76 and should have increased further when the audit for the year ending May 31, 1972, is presented.

Dues paying members, as well as total membership, have increased by one quarter. During most of this period, dues were \$40 per annum. With the greatly increased activities of the Association, the broadening of participation in health related spheres and the concurrent increase in funding of such activities, it has been necessary and prudent to utilize the concept of deficit financing in recent years. This has been weathered, although at times precariously, by returning to the coffers monies appropriated for committee activities but unspent at the end of the year, by investing liquid funds available until needed at the highest rates of interest available and secure, and by the vigilance of staff members, officers, and members of Council. In this way, we have been able to prevent an excess of income over expenses at the time of the annual audit even though at times the margin has been very close.

Since the Association has become involved in contractual agreements with the Federal Government, reasonably satisfactory reimbursement procedures have been realized utilizing both direct and indirect cost computation methods. Much credit is due our bookkeeper, Miss Thelma Franklin, and the above procedures are well outlined in the staff report of our Executive Director, Mr. Edwin F. Smith, in July, 1971. The Treasurer recommends this material as must reading for any members seriously interested in the financial operations of the Association.

The Treasurer would point out that there will always be a difference between the Summary-Comparison of Budgeted and Actual Operation and the auditor’s report since the former (Summary-Comparison) is on a cash basis whereas the Report of the Audit is on an accrual basis.

Lastly, but most importantly, the Treasurer wishes to point out that Miss Thelma Franklin, our bookkeeper, is retiring from that position. She has been a Rock of Gibraltar, has given unstintingly of her time and effort. Her knowledge and expertise have been of inestimable value. Devotion to her work, really the work of this Association, has been exemplary. Without exception, she has had a knowledgeable accounting of any query that the Treasurer might have had. The Association will miss her and as Treasurer, I should like to pay her tribute and express thanks for a job well done.

We are fortunate in obtaining the services of Mr. L. B. Storey to take over her position and the Treasurer wishes him the greatest success.

RECOMMENDATIONS

(1) It is recommended that the Staff Report on Finance System and Reporting Forms including the Staff Report to Council on Indirect Cost Computation be widely disseminated to members of this Association through whatever communication channels seem best to the Reference Committee.

(2) That the Association appropriately thank Miss Thelma Franklin for her years of devoted service.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the Report of the Treasurer with the deletion of the word “the” and the substitution of the words “an updated” on line 28, Recommendation (1), and the addition on line 31 of the words “publication in the *Journal of the Medical Association of Georgia*” and the deletion of lines 32 and 33, so that the recommendation would read as follows:

“(1) It is recommended that an updated Staff Report on Finance System and Reporting Forms including the Staff Report to Council on Indirect Cost Computation be widely disseminated to the members of this Association through the publication in the *Journal of the Medical Association of Georgia*.”

Your reference committee wishes to heartily thank Dr. John S. Atwater for his 10 years of devoted service as Treasurer of this organization (*at that point, Dr. Atwater was given a standing ovation as a token of appreciation for his service to MAG*).

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer as amended by the reference committee.

Supplemental Report 72-5
Budget for Fiscal Year 1972-73

C. E. Bohler, M.D., *Chairman*

The attached budget for fiscal year June 1, 1972-May 31, 1973 is referred to the House of Delegates for endorsement.

SUMMARY-COMPARISON OF BUDGETED & ACTUAL OPERATIONS

MEDICAL ASSOCIATION OF GEORGIA
Period June 1, 1971 to April 28, 1972

	<i>Budget</i> 6/1/71 5/31/72	<i>Actual</i> 6/1/71 4/28/72	<i>(Over)</i> <i>Under</i> <i>Budget</i>	<i>'72-'73</i> <i>Proposed</i> <i>Budget</i>
INCOME				
I. (a) MAG Dues	\$126,000.00	\$323,960.00	(\$197,960.00)	\$320,000.00
(b) Int. & AMA	9,500.00	12,879.88	(3,379.88)	11,000.00
(c) GP Service	3,250.00	2,708.30	541.70	3,250.00
(d) Additional Dues		280.00	(280.00)	
(e) Parking	6,000.00	7,699.56	(1,699.56)	6,000.00
II. ANNUAL SESSION	8,000.00	5,100.00	2,900.00	7,000.00
III. JOURNAL	40,000.00	37,928.40	2,071.60	46,000.00
IV. RENT		5,450.00	(5,450.00)	
V. CONTINGENT				
Trans. from Opr. Cap.	198,391.25		198,391.25	16,240.00
March Council Add.	6,302.13		6,302.13	
Dec. Council Add.	2,000.00		2,000.00	
TOTAL INCOME	\$399,443.38	\$396,006.14	\$ 3,437.24	\$409,490.00
EXPENSES				
I. (a) Fixed Allotments	\$ 99,236.75	\$ 90,351.08	\$ 8,885.67	\$102,945.00
(b) Association Office	152,371.82	127,652.22	24,719.60	158,220.00
(c) Association Comm.	55,870.00	23,709.77	32,160.23	61,645.00
(d) Related MAG Activ.	3,425.00	2,425.00	1,000.00	3,925.00
(e) Exec. Comm. Dis. Fund	1,000.00	217.84	782.16	1,000.00
(f) Contingent-Trans. from Opr. Cap.	18,302.13	16,851.81	1,450.32	10,000.00
II. JOURNAL	\$ 53,937.68	\$ 50,576.26	\$ 3,361.42	\$ 56,455.00
III. DEPRECIATION				
Building	15,000.00		15,000.00	15,000.00
Equipment	300.00		300.00	300.00
TOTAL EXPENSES	\$399,443.38	\$311,783.98	\$ 87,659.40	\$409,490.00
LIQUID FUNDS AVAILABLE				
I. C & S Checking	\$ 50,717.48			
C & S Certificates	110,000.00	(4½ %)		
Decatur Federal	200,000.00	(5½ %)		
Includes the following Restricted Funds:				
Equipment Depreciation	1,242.79			
Building Depreciation	49,600.00			

	<i>Budget</i> 6/1/71 5/31/72	<i>Actual</i> 6/1/71 4/28/72	<i>(Over)</i> <i>Under</i> <i>Budget</i>	<i>'72-'73</i> <i>Proposed</i> <i>Budget</i>
I. (a) FIXED ALLOTMENTS				
Prin. & Int. on Mort.	\$ 54,495.00	\$ 49,953.75	\$ 4,541.25	\$ 54,495.00
MAG Atty. Expenses	700.00	259.75	440.25	
MAG Retainers	7,200.00	6,750.00	450.00	14,000.00
President's Honorarium	2,400.00	2,400.00		2,400.00
Annual Audit	2,500.00	2,500.00		2,700.00
Taxes	17,817.13	17,817.13		21,000.00
Retirement Contrib.	9,624.62	9,045.15	579.47	3,600.00
Retirement Trust Fee	200.00	200.00		250.00
Woman's Auxiliary	4,300.00	1,425.30	2,874.70	4,500.00
TOTAL FIXED	\$ 99,236.75	\$ 90,351.08	\$ 8,885.67	\$102,945.00
(b) ASSOCIATION OFFICE				
Salaries	\$143,400.00	\$124,863.30	\$ 18,536.70	\$130,000.00
Insurance & Bonds	9,000.00	5,643.38	3,356.62	9,000.00
Payroll Tax	6,551.82	4,642.38	1,909.44	6,500.00
Travel-President	2,000.00	1,207.12	792.88	3,000.00
Travel-Pres. Elect	800.00	653.00	147.00	1,200.00
Travel-Past Pres.	800.00	800.00		1,200.00
Travel-Office	6,000.00	6,000.00		11,750.00
Travel-Exec. Comm.				4,800.00
Travel-Del. & Sec., AMA				
Ann. & Clinical	4,000.00	3,196.87	803.13	6,000.00
Travel-Alt. Delegates	3,500.00	290.50	3,209.50	4,500.00
Macon Office Rent				1,440.00
Maintenance				
Building	2,750.00	2,019.86	730.14	2,750.00
Equipment	800.00	870.74	(70.74)	1,000.00
Tel. & Tel.	4,500.00	3,664.71	835.29	4,500.00
Postage	6,000.00	4,679.38	1,320.62	7,000.00
Office Supplies	6,000.00	4,291.72	1,708.78	6,000.00
Janitorial Svc., Sup. & Security	8,800.00	7,664.20	1,135.80	8,800.00
Meetings	2,000.00	756.82	1,243.18	2,000.00
Dues & Subscript.	470.00	310.00	160.00	580.00
Electric, Water, Heat	8,800.00	8,738.16	61.84	10,000.00
Sundry	200.00	144.96	55.04	200.00
Equipment	1,000.00	1,000.00		1,000.00
	\$217,371.82	\$181,436.60	\$ 35,935.22	\$223,220.00
Reimbursable Expense	65,000.00	53,784.38	11,215.62	65,000.00
	\$152,371.82	\$127,652.22	\$ 24,719.60	\$158,220.00
(c) ASSOCIATION COMMITTEES				
<i>Standing</i>				
Annual Session	\$ 16,350.00	\$ 8,974.48	\$ 7,375.52	\$ 17,535.00
Emergency Medical Service	700.00	279.39	420.61	700.00
Professional Conduct	590.00		590.00	590.00
<i>Special</i>				
Awards	280.00	45.62	234.38	400.00
Blood Banks	25.00		25.00	50.00
Cancer	500.00	77.00	423.00	400.00
Communications	3,550.00	2,709.08	840.92	4,750.00
Ecological Health	600.00		600.00	700.00
Education	2,075.00	863.13	1,211.87	3,000.00
Government Prog. & Med. Svc.	1,200.00	255.86	944.14	1,500.00
Historical	50.00		50.00	50.00
Insurance & Economics	1,400.00	500.00	900.00	1,625.00
Legislation	3,600.00	3,600.00		4,200.00
Long Range Planning				3,000.00
Maternal & Infant Welfare	150.00	54.40	95.60	150.00
Medicine & Religion	50.00	10.04	39.96	150.00

	<i>Budget 6/1/71 5/31/72</i>	<i>Actual 6/1/71 4/28/72</i>	<i>(Over) Under Budget</i>	<i>'72-'73 Proposed Budget</i>
Mental Health	600.00	467.00	133.00	650.00
Occupational Health	475.00	434.44	40.56	275.00
Peer Review	1,250.00	117.00	1,133.00	750.00
Physician-Lawyer Liaison	50.00		50.00	50.00
Private Practice	50.00		50.00	50.00
Quackery	17,000.00	1,313.17	15,686.83	16,000.00
Rural Health	1,450.00	872.87	577.13	1,520.00
School Child Health	2,000.00	1,636.29	363.71	2,000.00
Talmadge Hospital Liaison				50.00
Contribution GaMPAC	1,500.00	1,500.00		1,500.00
Woman's Aux. Adv. (AMA-ERF)	375.00			
	<u>\$ 55,870.00</u>	<u>\$ 23,709.77</u>	<u>\$ 32,160.23</u>	<u>\$ 61,645.00</u>
(d) RELATED MAG ACTIVITIES				
AMA Delegates	\$ 2,200.00	\$ 2,200.00		\$ 2,700.00
Interprofessional Council	125.00	125.00		125.00
SAMA	500.00	100.00	400.00	500.00
SAMA-MAG Annual Session	450.00		450.00	450.00
SMEB	150.00		150.00	150.00
	<u>\$ 3,425.00</u>	<u>\$ 2,425.00</u>	<u>\$ 1,000.00</u>	<u>\$ 3,925.00</u>
(e) EXECUTIVE COMMITTEE				
Discretionary Fund	\$ 1,000.00	\$ 217.85	\$ 782.16	\$ 1,000.00
(f) CONTINGENT FUND				
Transfer from Oper. Cap.	10,000.00			\$ 10,000.00
Dec. Council Addition	2,000.00			
Mar. Council Addition	6,302.13			
Past President's Travel		3.43		
Travel Office		3,165.98		
Legislative Special		4,993.09		
Legislation		2,287.62		
AMA Delegates Meetings		48.70		
Feasibility Study		2,651.06		
Taxes		1,811.85		
Equipment		276.49		
Southern Governors Conf.		1,500.00		
Walker's Campaign		113.39		
	<u>\$ 18,302.13</u>	<u>\$ 16,851.81</u>	<u>\$ 1,450.32</u>	<u>\$ 10,000.00</u>

II. JOURNAL

Printing	\$ 38,325.00	\$ 37,093.94	\$ 1,231.06	\$ 40,000.00
Salaries	9,645.00	8,612.87	1,032.13	10,200.00
Insurance	937.68	469.15	468.53	905.00
Payroll Tax	700.00	534.44	165.56	750.00
Engraving & Cuts	2,400.00	2,101.28	298.72	2,500.00
Postage & Copyright	1,500.00	1,373.90	126.10	1,600.00
Clipping Service	180.00	174.82	5.18	200.00
Addressograph & Supplies	200.00	193.09	6.91	250.00
Sundry	50.00	22.77	27.23	50.00
	<u>\$ 53,937.68</u>	<u>\$ 50,576.26</u>	<u>\$ 3,361.42</u>	<u>\$ 56,455.00</u>

REFERENCE COMMITTEE RECOMMENDATION
 —Your reference committee recommends approval of the Budget with the following changes made necessary by the inadvertent omission of \$530.00 in the budgetary request of the Education Committee and approved by Council, so that the Budget would read on

Page 1, *Income, Item V*, \$16,240.00, and *Total Income* be changed to read \$409,490.00. Under *Expenses, Item I (c) Association Committees* be changed to \$61,645.00, and that *Total Expenses* be changed to \$409,490.00. On page 3, *Special Committees—Education* be changed to \$3,000.00, and total Committee

expenses be changed to \$61,645.00. Also on page 3, Association Committees—Standing, that Emergency Medical Service Committee be changed to \$700.00 and Professional Conduct Committee be changed to \$590.00 to correct transposition in typing.

Your reference committee recommends the following items be referred to the Long Range Planning Committee for study and implementation. These items are "to define the functions and responsibility of the Finance Committee, to consider the possibility of making the Finance Committee Chairman a member of the Long Range Planning Committee, to consider the possibility of making the Editor of the *Journal of the Medical Association of Georgia* an ex-officio member of the Finance Committee, and to establish the responsible person or persons for the investment of liquid funds. As was obvious from the testimony given before this reference committee, Association Committee appointments need to be made as early as possible in the year so that budgetary requests may be studied earlier and in greater depth by the Finance Committee. Realizing this action has been referred already to the Long Range Planning Committee, this reference committee would like to recommend that this receive high priority on their agenda.

All of the numerical changes recommended by the reference committee have been incorporated in the proposed budget printed above.

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report 72-5 as amended by the reference committee.

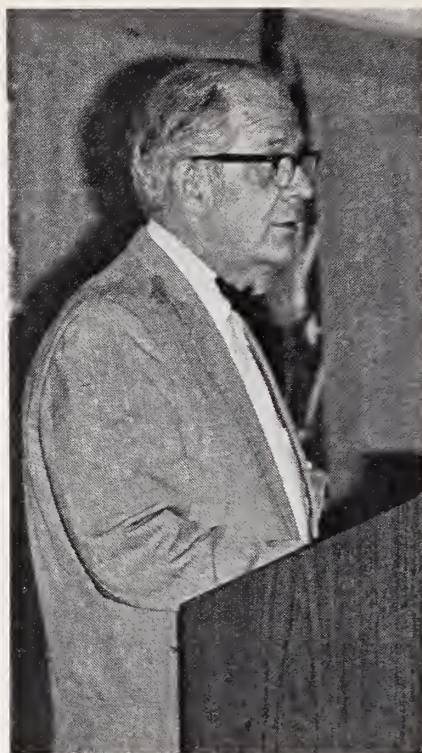
Chairman Atwater then thanked the members of the reference committee for their time and effort and moved that the committee report be adopted as a whole.

Speaker Rogers then announced the MAG election returns as reported by Dr. John P. Tucker for the Tellers Committee. The election results were:

President-Elect—C. Emory Bohler, M.D., Brooklet
 Second Vice President—H. Hilt Hammett, M.D., La-Grange
 Secretary—Earnest C. Atkins, M.D., Decatur
 Treasurer—Carson B. Burgstiner, M.D., Savannah
 AMA Delegate—J. Frank Walker, M.D., Atlanta
 AMA Delegate—Preston D. Ellington, M.D., Augusta
 AMA Alternate Delegate—J. Daniel Bateman, M.D., Albany
 AMA Alternate Delegate—F. William Dowda, M.D., Atlanta
 Vice Speaker—J. Rhodes Haverty, M.D., Atlanta

The Speaker then recognized Delegate Louis H. Felder, Atlanta, for the purpose of presenting a resolution to the House of Delegates. Dr. Felder noted that copies of Resolution 72-10 had previously been distributed to members of the House, and requested that the Delegates take this matter back to their local county medical societies for discussion and consideration.

At this point, the Speaker reminded Dr. Felder that resolutions could be presented to the House on the final day only under the unanimous consent



Harrison L. Rogers, Jr., M.D., Speaker of the MAG House of Delegates.

rule. The Speaker then asked if there was objection to the presentation of this resolution, and hearing no objection, declared unanimous consent to have been given.

Resolution 72-10

Access to Health Care

LOUIS H. FELDER, M.D.

WHEREAS, the MAG is acutely aware of the economic unfeasibility of National Health Insurance to the American taxpayer, and

WHEREAS, the most destructive feature of National Health Insurance is the loss of autonomy of the patient and the physician in the development of a mutually dependent interpersonal relationship,

NOW THEREFORE BE IT RESOLVED THAT, MAG immediately publicize through every newspaper in the State, as well as such other media as may be feasible, that it will

(a) Identify the people of this State who do not have access to adequate medical care, and

(b) It will see to it that they have access to such adequate medical care as they need and will accept.

(c) That MAG will request only such funds from the State and Federal Governments as may actually be needed to implement these functions.

(d) Keep the public continually informed thru the news media as to the nature of its efforts, the extent of its successes, the reasons for the temporary obstructions and delays and the cost of its program.

(e) Will encourage every other State Medical Association to immediately do likewise.

HOUSE OF DELEGATES ACTION—Following discussion, Delegate J. Rhodes Haverty moved that resolution 72-10 be referred to the Council. This motion was approved by the House.

Delegate Menard Ihnen, Augusta, was recognized and moved that the House give Speaker Rogers a rising vote of confidence and an expression of its appreciation for the splendid job he has done in performing the duties of Speaker.

The Speaker called for new business, and there being none, he then thanked all members of reference committees for their diligent work, members

of the MAG Headquarters Staff for their assistance, and entertained a motion for adjournment for the Second Session for the MAG House of Delegates. On motion duly made and seconded the House was adjourned and the meeting turned back over to President Mitchell for the continuation of the Second General Business Session of the MAG General Session.

MAG Second General Session (Reconvened)

118th Annual Session of the Medical Association of Georgia

Sunday May 14, 1972

PRESIDENT MITCHELL then reconvened the Second Session of the 118th Annual Session of the Medical Association of Georgia and expressed his appreciation to Dr. Harrison Rogers and Dr. Preston Ellington for their efficient handling of the business of the House of Delegates.

Dr. Mitchell then called for the drawing of the exhibit attendance prize and asked Mrs. Jackie Burgstiner to assist in the drawing. He then announced the winner, Dr. Cecil A. White, of Augusta, and Dr. White was presented with a portable television set as the exhibit attendance prize.

Installation of Officers

President Mitchell then asked the incoming President, the officers, the AMA Delegates and Alternates, the Councilors and the Vice Councilors, to please assemble in front of the speaker's platform for the installation of officers as follows:

- President—F. William Dowda, *Atlanta* (1973)
- President-Elect—C. Emory Bohler, *Brooklet* (1973)
- Immediate Past President—W. C. Mitchell, *Smyrna* (1973)
- First Vice President—Braswell E. Collins, *Macon* (1973)
- Second Vice President—H. Hilt Hammett, *La-Grange* (1973)
- Secretary—Earnest C. Atkins, *Decatur* (1972-75)
- Treasurer—Carson B. Burgstiner, *Savannah* (1972-75)
- Vice Speaker—J. Rhodes Haverty, *Atlanta* (1972-75)
- Second District Vice Councilor—Frank R. Miller, *Thomasville* (1973)

- Sixth District Councilor—W. E. Barron, *Newnan* (1974)
- Sixth District Vice Councilor—Norman P. Gardner, *Thomaston* (1974)
- Ninth District Councilor—Paul T. Scoggins, *Commerce* (1975)
- Ninth District Vice Councilor—Robert S. Tether, *Gainesville* (1975)
- Tenth District Councilor—Edwin W. Allen, Jr., *Milledgeville* (1975)
- Tenth District Vice Councilor—M. A. Hubert, *Athens* (1975)
- Cobb County Medical Society Councilor—Remer Y. Clark, Jr., *Marietta* (1975)



Outgoing President W. C. Mitchell, M.D. (l.) with his successor, F. W. Dowda, M.D.

Cobb County Medical Society Vice Councilor—Charles R. Underwood, *Marietta* (1975)

DeKalb County Medical Society Councilor—L. C. Buchanan, *Decatur* (1975)

DeKalb County Medical Society Vice Councilor—Luther M. Vinton, Jr., *Avondale Estates* (1975)

Medical Association of Atlanta Councilor—Fleming L. Jolley, *Atlanta* (1975)

Medical Association of Atlanta Vice Councilor—Thomas J. Anderson, *Atlanta* (1975)

Richmond County Medical Society Councilor—Ronald F. Galloway, *Augusta* (1975)

Richmond County Medical Society Vice Councilor—Henry D. Scoggins, *Augusta* (1975)

AMA Delegate—J. Frank Walker, *Atlanta* (January 1, 1973 to December 31, 1974)

AMA Delegate—Preston D. Ellington, *Augusta* (January 1, 1973 to December 31, 1974)

AMA Alternate Delegate—J. Daniel Bateman, *Albany* (January 1, 1973 to December 31, 1974)

AMA Alternate Delegate—F. William Dowda, *Atlanta* (January 1, 1973 to December 31, 1974)

President Mitchell administered the oath of office to the assembled new officers of MAG and declared each of these new officers duly installed. Dr.

Mitchell then turned the gavel of leadership over to Incoming President F. William Dowda, who expressed his appreciation to those present for the honor of being selected President for 1972-73. President Dowda then presented to outgoing President Mitchell the President's Key and a bound volume containing the issues of the *Journal of the Medical Association of Georgia* published during Dr. Mitchell's term as President.

President Dowda then announced that the new MAG Council and Executive Committee would hold their organizational meetings immediately and entertained a motion for adjournment of the 118th Annual Session. The house adjourned at 12:05 p.m.

Official Attendance at the 118th Annual Session was:

577	Members
115	Guest M.D.s
83	Other Guests
285	Woman's Auxiliary
177	Exhibitors
1,237	TOTAL REGISTRATION

MAG PERSONNEL CHANGES

Mr. James Mincy Moffett has been appointed Executive Director of the Medical Association of Georgia, effective May 15, 1972.

Employed as Assistant Executive Director of MAG since 1961, Mr. Moffett was born in Dublin, Ga. Upon graduation from the University of Georgia and completion of military service, he assumed the position of secretary to the Hon. James C. Davis, Member of Congress representing the Fifth Congressional District, Ga.

During his years of service to MAG, Mr. Moffett has proven himself to be extremely valuable as "our man at the Capitol," and especially in his efforts to protect and improve organized medicine in Georgia.

Married to the former Ann Charlotte Stevens of Columbus, Ga., the Moffetts have two sons; James Mincy, Jr., and Randolph Rutherford.

Mr. A. R. Jablonowski, formerly Assistant Director, Health Planning, has been promoted to the position of Associate Director. This appointment was effective May 15.

We would also like to take this opportunity to officially introduce Mr. L. B. Storey, Jr., Assistant Director, Business and Finance.

Born in Macon, Ga., Mr. Storey was graduated from Fulton High School in Atlanta and the Draughon School of Commerce. He also attended Georgia

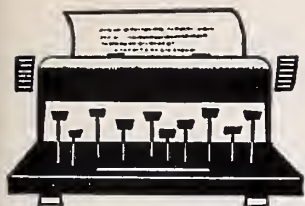
State College, leaving there to serve in the Army Air Force as a meteorologist with the rank of sergeant.

He comes to us from the Medical Association of Atlanta, where he had been employed for the last three years.

Mr. Storey is a member of the First Baptist Church of Hapeville, where he teaches a men's Sunday School class. He and his wife, Mary, live at 3343 Northside Dr., Hapeville, Ga.



Mr. L. B. Storey, Jr., Assistant Director, Business and Finance.



Charles Emory Bohler, MAG President-Elect

CHARLES EMORY BOHLER, a Family Practitioner from Brooklet, Ga., was installed as President-Elect of the Medical Association of Georgia at the Association's 118th Annual Session at the Macon Hilton Hotel, Macon, May 11-14.

Dr. Bohler, born in Statesboro, Ga., in 1924, was graduated from the Medical College of Georgia in 1954, and interned at the Columbia Hospital of Richland County, Columbia, S. C. He has practiced in Brooklet since 1956.

A member of the Brooklet United Methodist Church, Dr. Bohler is also a member and past president of the Kiwanis, and is an avid booster of Brooklet's high school band and football team. His hobbies are fishing and hunting.

Married to the former Billie Jean Parker, the Bohlers have four children: daughters Rene, 19 and Ellen, 16; sons Matt, 14 and Tim, 12.

Highlights of the 1972 MAG Annual Session

THE 118TH ANNUAL SESSION of the Medical Association of Georgia was held in Macon, May 11-14, 1972. Over 1,200 registered including physicians from all parts of the state, local and national exhibitors and guests.

The tennis and golf tournaments, as well as the third annual MAG Art Show, provided members and their families an opportunity to show their athletic and artistic skills.

Most of the specialty societies met during the Annual Session, presenting extensive scientific programs. In addition, special programs included: a most thought-provoking presentation by Dr. H. E. Godfrey of Manchester, England, concerning the danger that threatens American medicine in the form of socialized medicine; a panel discussion, "Health Care Delivery Systems, Past, Present and Future"; and a three-topic panel on "Management of Syphilis and Gonorrhea," "Sex in Schools" and "Dynamics of Violence."

The MAG House of Delegates met in conjunction with the Annual Session and considered numerous reports and resolutions, some of which are detailed herein. A detailed report of each proposal presented, the subsequent recommendation of the Reference Committee to which it was referred and the final action taken by the House appears elsewhere in this issue.

Election of Treasurer

The House adopted the recommended changes in the Constitution and Bylaws to allow for the election of a Treasurer who shall serve as a voting member of Executive Committee and Council, shall serve three-year terms of office and shall be eligible to succeed himself for one term.

Quackery

The House approved the report of the Committee on Quackery, reiterating that Chiropractic remains the overriding quackery problem in Georgia and that effectively controlling Chiropractic remains as a major objective with high priority. It also recommended that at the appropriate time legislation to curb the activities of Chiropractors be sponsored with aggressive support from all sections of the profession.

Zero Population Growth

Adopting the Report of the Maternal and Infant Welfare Committee as amended by the Reference Committee, the House recommended that: MAG members participate more fully in the state's Family Planning Program; MAG assist in educating the public as to the availability of prenatal, delivery and post partum care, pediatric care and family planning; MAG foster the concept of a zero rate population growth.

Osteopathic Membership

The House adopted the report of the Reference Committee recommending disapproval of allowing osteopaths membership in MAG but did approve the establishment of a liaison committee to the Georgia Osteopathic Association to further explore the possibilities of MAG membership for osteopaths with full practice licenses.

Podiatry

Due to a ruling made by the state's attorney general which allowed podiatrists to be included under the definition of Doctors of Medicine, a resolution was introduced and adopted by the House to contest and challenge this ruling in order to protect the public from inadequately trained and uncontrolled individuals.

Third Party Interference

The House adopted a resolution to investigate insurance companies which provide policies under which payment of local expenses, court costs and penalties are made in behalf of policyholders in cases where physicians seek to recover legitimate fees from delinquent patients.

Decentralized Medical Education

The concept of decentralized medical education was approved by the House. County medical societies were encouraged to assist in the development of "satellite centers of medical education" that would involve in some way all of the hospitals in an area, which wished to participate.

Continuing Education

The House adopted the recommendation of the Education Committee which sought to establish the MAG as the responsible accrediting agency for local postgraduate programs for continuing education as urged by the AMA.

However, based on extended discussion before the reference committee, the House approved the reference committee report to not endorse the imposing of a continuing education requirement as a requisite for maintaining active membership in MAG.

Disciplinary Procedures

Registering concern for the public and physicians who serve on review committees, the House approved the report of the reference committee to urge the state

legislature to amend the laws of Georgia in order to provide adequate and effective self-disciplinary procedures for the protection of the public from unfit practitioners. Also, it voted to encourage legislation that would provide immunity from litigation to physicians serving on review committees and laws to prevent exposure of records of such review committees.

Labeling of Medications

The House approved a recommendation directing MAG's Council to establish a program of information directed to all physicians and pharmacists concerning the need for labeling of medications in our mobile society today.

Georgia Medical Care Foundation

The House adopted the reference committee report to disapprove a resolution disassociating the Georgia Medical Care Foundation from the Medical Association of Georgia. The Foundation was commended for its accomplishments to date and urged to improve its operations, procedures and communication efforts by having Foundation representatives meet with county medical societies. The House also recommended that the Foundation submit to it a detailed annual activities report.

Socio-Economics Seminar

A good deal of support was voiced in discussions concerning the Socio-Economics Seminar and the House approved the institution of such a Seminar on the Socio-Economics of Medical Practice in Atlanta and Augusta for medical students, interns, residents and their wives in an effort to bring these individuals closer to organized medicine as they enter practice.

EMCRO

The House of Delegates endorsed the Association's application for an Experimental Medical Care Review Organization with some reservations concerning its ultimate purpose and the use to which its findings might be put. An additional requirement imposed by the House was that before the EMCRO became an operational program the approval of the House be obtained.

MAGNET

The House approved the changing of the name of the Annual County Society Officers' and New Members Conference to Medical Association of Georgia New Educational Training. Also approved was the opening of this Conference to all MAG members, especially new members and officers.

Burns Center

Approval was given by the House to the recommendation of the Emergency Medical Service Committee that the MAG support efforts to establish a statewide Burns Center located at the Medical College of Georgia.

Professional Standards for Athletic Trainers

Action taken by the House on the report of the School Child Health Committee included encouraging the Committee to set up standards, not requiring legislation, for athletic trainers.

Woman's Auxiliary

The House voted to commend the Auxiliary and expressed its thanks for their great contribution to MAG. The Auxiliary was asked to consider taking responsibility for the Health Careers Council of Georgia. Also approved was a recommendation that county medical societies with membership of 10 or more encourage their wives to organize county auxiliaries.

Access to Health Care

The House gave unanimous consent to the introduction of a resolution concerning access to health care during its second session. This resolution, referred by the House to Council for study, proposed that MAG identify those Georgians who do not have access to adequate medical care and see to it that they have access to it, with a request for state and federal financial support as necessary for implementation of the project and with wide public dissemination of information about MAG's efforts.

Awards Presented

Thomas N. Lumsden, M.D., Clarkesville, was selected as recipient of the 1972 Family Physician of the Year Award; Edwin W. Allen, Sr., M.D., Milledgeville, was presented with the Distinguished Service Award; William E. Lewis, M.D., Macon, received the Civic Endeavor Award.

Scientific Exhibit Awards were presented as follows: First Place, "Examination of the Hand," by James L. Becton, M.D., and Joe D. Christian, M.D., Augusta, Georgia; Second Place, "Case Vignettes From a Community Hospital," Department of Pathology, Medical Center of Central Georgia, Macon, Georgia; Third Place, "Middle Georgia Council on Drugs," Robert Donner, M.D., President of the Council, sponsored by the Bibb County Medical Society, Macon, Georgia.

The following GaMPAC Awards were presented: Highest Percentage of GaMPAC Membership in a County Medical Society—Ogeechee River Medical Society; Highest Percentage of GaMPAC Membership in a Congressional District—Fourth District; Largest Total Dollar Contribution to GaMPAC—Medical Association of Atlanta.

Officers

MAG officers elected and/or installed for the 1972-73 Association year were: F. William Dowda, M.D., Atlanta, President; C. Emory Bohler, M.D., Brooklet, President Elect; Braswell E. Collins, M.D., Macon, First Vice President; H. Hilt Hammett, Jr., M.D., LaGrange, Second Vice President; Earnest C. Atkins, M.D., Decatur, Secretary; Carson B. Burgstiner, M.D., Savannah, Treasurer; J. Rhodes Haverty, M.D., Atlanta, Vice Speaker; J. Frank Walker, M.D., Atlanta and Preston D. Ellington, M.D., Augusta, AMA Delegates; J. Daniel Bateman, M.D., Albany, and F. William Dowda, M.D., Atlanta, AMA Alternate Delegates.

Future Annual Session Meeting Sites

Future sites of MAG Annual Sessions were announced as follows: Augusta, 1973; Savannah, 1974; Atlanta, 1975; Jekyll Island, 1976; Macon, 1977; Augusta, 1978; Savannah, 1979; Atlanta, 1980.

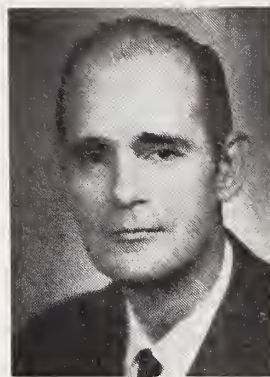
Tumor Conference—South Fulton Hospital

9 A.M. TO 1 P.M. — JULY 8, 1972

Luther Brady, M.D., Hahnemann Medical College, Philadelphia:
"External Radiation Therapy."

Irving Ariel, M.D., Pack, New York: "Internal Radiation Therapy."

Andrew Gage, M.D., USVA Hospital, New York, N.Y.:
"Cryosurgery in Cancer."



YOUR MEDICAL ASSOCIATION AND THE WAGE PRICE FREEZE

AERICAN MEDICINE, which I feel has taken such magnificent care of the medical needs of the people in this country over a period of many, many decades, has become the whipping boy over the last 12 years of politicians trying to make Brownie points with their constituents. These politicians have variously concocted the following falsehoods, which I shall have an opportunity to discuss with you during the coming year. These popular fallacies are (1) that there is a serious doctor shortage in this country (which I contend there is not), and (2) that there is a serious lack of medical skill amongst the practitioners of this country (which again I contend there is not). Number three, serious doubt has been cast upon the honesty and integrity of a majority of the physicians and I consider that this doubt is a slanderous falsehood; (4) that the physicians are responsible for the economic plight of the country in the field of medical care.

This supposition, actually, has eventuated in a series of unreasonable decisions which are most unfortunate and inexplicable. For a period of four decades—that period of time since the great depression—America has desperately been trying to spend itself into the poorhouse and has practiced the economics of taxation by inflation throughout this entire period of time. The temporary adherence of such a policy provided a very necessary shot in the arm to our economic situation back in the 1930's, during which time I had the pleasure of being a child, but has led us almost to the brink of economic disaster. We probably in this country now have the most highly paid and the most poorly motivated working force of any country in the world. We have, because of this very problem, almost priced ourselves out of the world market and were rapidly pricing ourselves out of the market at home when President Nixon took affirmative action in this direction. I certainly heartily concur with the necessity of all of these economic measures, including the wage-price control.

The Board has, however, over a period of months made three decisions that are intolerable and which your Medical Association has formally requested an audience with the Board in order to lodge a protest. I think, if the protest is ineffectual, that we should indeed sue the legality of the President's action, although I am in basic sympathy with some continued wage-price controls, if they are reasonably and equitably applied for probably the next 12 months.

These decisions have been (1) not to allow physicians the same increase in their fees that is allowed other income producers. For example, the nurse in your office may receive a 5½ per cent increase in her income, but this is not permissible in your circumstances. A 2½ per cent increase is permissible when justified by expenditures, but only when justified by expenditures.

Number two is that in Medicare and Medicaid, instead of allowing usual increase to occur, the Wage-Price Board has ruled that the only increase that can

PRESIDENT'S LETTER / Continued

occur in these two programs is 2½ per cent of the screen which was in operation in November of 1971, which means that we are still operating a year-and-a-half behind in our fees for these two programs. At the end of this year, we will be operating two-and-a-half years behind.

The third and most unfair part of this indicates the government's prejudice against the private practicing physician as expressed by this panel and that is the allowance of institutional providers to hire physicians to raise these physicians' income by 5½ per cent and pass the cost on, which the private practicing physician is not allowed to do. I do hereby publicly and formally protest these actions and have written to Washington for a hearing. You may rest assured that during the coming 12 months we will continue to fight this to the best of our ability.



*F. W. Dowda, M.D.
President, Medical Association of Ga.*

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

Sunday, April 16, 1972

Finance: Approved the expenditure of \$26.00 within the Budget of the Committee on Insurance and Economics for the printing of cards to post in MAG Members' offices regarding fee list availability.

Board of Human Resources: Voted that Drs. Eldridge, Rogers, Buchanan, Haverty, and Wells should again represent MAG at a meeting of the Nominating Commission, April 29. Approved an all member mailing from MAG representatives on the Nominating Commission to report on their activity.

Foundation: Reviewed Foundation finances and, on learning that the Medicaid Contract would be amended to pay for the month of January previously lost, suggested that the Foundation Board consider reimbursing MAG the amount owed at this time.

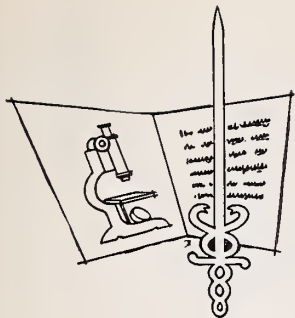
Headquarters Building Expansion: Instructed staff to arrange for a progress report to the House of Delegates by the architects.

Legal Counsel: Recognized the potential for a Resolution on changing MAG's Legal Counsel, and anticipating therefore that Alston, Miller and Gaines would resign, authorized Secretary Haverty to contact them and then appointed Drs. Haverty, Robert Wells and J. Frank Walker as a Legal Counsel Liaison Committee to seek a new firm if necessary.

Committees: Approved a report endorsing the current committee structure and appointed all committees for Fiscal Year 1972-73.

Staff: Accepted the resignation of Edwin F. Smith, Executive Director. Named James M. Moffett to position of acting Executive Director, effective May 15, and instructed the Committee on Long Range Planning to investigate details of a management study.

Next Meeting: 10:00 a.m., Wednesday, May 10, Macon Hilton Hotel.



PUBLIC AND PROFESSIONAL EDUCATION

LAMAR S. MCGINNIS, M.D.,* *Decatur*

DOES THE AMERICAN CANCER SOCIETY only ring a bell with you in the spring, when a volunteer calls for a contribution? If so, then perhaps you are missing some valuable benefits to be gained from knowledge of our local division activities in Georgia.

The State Board of Directors is continually engaged in promoting educational activities for the public and the profession. Many take advantage of these programs, while many others do not. Better participation is our goal, and ultimately, improved patient care.

Education of the public and education of the profession go hand in hand. Ostomy patients learn of improved techniques for the care of their ostomies, with the latest convenience, methods and equipment, through our "Ostomy Counseling and Rehabilitation Program," then the profession fulfills these expectations, in hospital, office, and home care. Patients find breast lumps through "Self-Examination," then obtain appointments with physicians and have these lumps properly assessed and acted upon. Post mastectomy patients needing exercise programs, prostheses, and psychological support, then have the "Reach to Recovery" program made available to them. Patients desiring a "Cancer Detection Examination" are able to get an appointment with a physician that will carry out this examination completely, including a proctosigmoidoscopic examination, and offer the patient the reassurance that at least, no cancer was detected at that time.

The "Day of Cancer," held each year in conjunction with the Atlanta Postgraduate Medical Assembly, should be supported by excellent attendance. Fine programs such as "Advanced Mammary Cancer," held at St. Joseph's Hospital; "Chemotherapy of Solid Tumors," held at Callaway Gardens; "Nuclear Medicine," held at Emory; and "Current Concepts in the Diagnosis and Treatment of Head and Neck Tumors," to be held June 9-10 in Augusta, should have better than the usual 60 to 70 physicians in attendance. Suggestions for programs should be forwarded to the Georgia Division of the American Cancer Society.

In 1948 the University of Michigan made a survey on public knowledge regarding cancer on request from the American Cancer Society. They found the American public had very little information regarding cancer. Cancer was closeted in darkness with myths and old wives' tales. A tremendous public education campaign was launched, based on the "Seven Danger Signals." In my opinion, these seven danger signals remain as the most important information to be imparted to the public regarding early detection of cancer. Their early recognition, followed by appropriate action, is more feasible and practical than an annual physical examination, at this time.

* Member, Professional Educational Committee, State Board of Directors, Georgia Division, American Cancer Society.

Early detection and treatment remain the hallmark of success in cancer therapy. The differences in survival for early and late stages of cancer are exemplified by these statistics for relative five-year survival; breast—early, 85 per cent, late, 53 per cent; cervix—early, 78 per cent, late, 45 per cent; colon and rectum—early, 69 per cent, late, 39 per cent; bladder—early, 69 per cent, late, 20 per cent. Nothing is as vital to early detection and treatment as well informed doctors, nurses, and dentists. Thus, the American Cancer Society began professional education programs in 1949, and these continue today.

The Georgia Division of the American Cancer Society stands ready with films, monographs, bulletins, the *Journal* "CA," and a Speakers Bureau, along with the many fine programs listed above and more. An extremely competent and dedicated staff is available to assist in any way with public or professional education. Please support the division and call upon it for assistance.

365 Winn Way 30033

HIGHLIGHTS OF COUNCIL

May 10, 1972

Executive Committee Recommendations to Council: (1) Approved reimbursement of \$10,000 to Georgia Chapter, American Cancer Society; (2) Approved restoring budgets to full amounts requested; (3) Approved increase in auto travel allowance from 10¢ to 12¢ per mile; (4) Approved travel expenses for Executive Committee of Council except when meeting with AMA and Council.

Long Range Planning: Advised that AMA would be asked to conduct management survey of MAG structure as recommended by Executive Committee.

Building Expansion: Approved \$750 for an appraisal of the sale value of MAG Headquarters Building and property.

Georgia Medical Care Foundation: Heard Dr. Dowda advise that check for \$21,560 representing the Foundation's total indebtedness to the MAG had been sent to MAG.

Health Access Stations: Heard GRMP report that Ocmulgee Medical Society was opposed to location of Health Access Station in Rochelle (Wilcox County) but that other societies in the area approved. Council approved the idea of another meeting between GRMP officials and Ocmulgee Medical Society.

Private Facilities for Diagnostic Procedures: Approved submission of a Supplemental Report of Council for the House of Delegates urging use of private laboratory facilities for diagnostic work.

Velia Group: Authorized Dr. John T. Godwin to draft letter to the Governor opposing the type services provided by the Velia Group on the basis that such services are now available through pathologists across the state at no cost to the state.

Physician's Assistants: Requested Dr. Haverty to appoint task force to work with the Board of Medical Examiners to define physician's assistants duties.

Auxiliary: Heard final Council report from Mrs. George W. Statham and thanked her for her support.

AREA STROKE FACILITY

St. Joseph's Infirmary has received a grant from the Georgia Regional Medical Program to establish an Area Stroke Facility. The facility will develop a comprehensive approach to stroke care and will provide educational services to physicians, area hospitals, stroke patients and their families. Request for information about the educational services or patient referrals may be accomplished by contacting the admission office at St. Joseph's Infirmary (area code 404-525-4681), or the Director of the Area Stroke Facility, Dr. William H. Stuart (area code 404-261-9121).



INDICATIONS FOR CEREBRAL ANGIOGRAPHY IN CEREBROVASCULAR DISEASE

A Neurologist's Approach

WILLIAM H. STUART, M.D., *Atlanta*

THE DEVELOPMENT OF CEREBRAL ANGIOGRAPHY, used in association with clinical skills, has increased the diagnostic accuracy in cerebrovascular disease. The question then is not whether to use cerebral angiography, but when is it indicated in the stroke patient.

A set of rules describing the indications for cerebral angiography is not possible. Although some broad guidelines can be established, each case has to be considered on its own merits and the exact form of angiography to be undertaken must similarly be determined on the merits of the individual case. Factors such as age, concurrent medical diseases, preexisting neurologic deficits and the availability of adequate diagnostic facilities are all important in determining what should be undertaken. The only dogma that can be applied to cerebral angiography is that the angiogram should not be utilized as a screening procedure for vague neurological complaints. In these situations, benign noninvasive screening procedures such as brain scan, EEG, skull series and lumbar puncture should be used as well as careful clinical follow-up and accumulation of additional data that might provide a more specific reason for angiography.

In a broad sense, most patients with evidence of increased intracranial pressure, transient cerebral ischemic attacks, extracranial bruits with minor focal neurologic deficits and focal neurologic deficits of unexplained cause, should have cerebral angiography performed. Within this group, there will be specific contraindications to the study and certainly outside of this group, there will be patients who have additional specific indications for angiography.

The selection of a diagnostic procedure is a more difficult question. The clinician ideally needs a comprehensive view of the patient's intracranial and extracranial vasculature on a dynamic basis, using rapid sequence serial angiography. Single shot films for purposes of evaluating extracranial cerebrovascular disease are generally not adequate to evaluate the intracranial vasculature and to exclude the presence of non-vascular intracranial disease, such as malignancy and other mass lesions. All too often the patient will require an additional arteriotomy, compounding the risk that is associated with these procedures when single shot angiography is performed as the initial procedure. In our experience, femoral catheter angiography with selective visualization of the carotid and vertebral arteries, as well as the aortic arch, and subsequent rapid sequence AP and lateral injections of the carotid arteries and usually the vertebral artery, provide a complete evaluation of the patient. The use of biplane technique has reduced the numbers of injections necessary to accomplish this procedure and consequently reduce the patient risk.

The practices outlined above are in no way an attempt to limit the techniques of angiography but are a statement of the neurologist's approach to the evaluation of cerebrovascular disease.

265 Ivy St., N.E. 30303

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

THE ASSOCIATION



NEW MEMBERS

Beaird, Robert L., Jr. Muscogee—Associate	Medical Center Columbus, Georgia 31902
Billips, William C. DeKalb—Active—Oph	3576 Chamblee Tucker Road Atlanta, Georgia 30341
Bolton, Richard S. T-B-G—Associate—Ph	P. O. Box 148 Thomasville, Georgia 31792
Cohen, Richard W. Cobb—Active—Or	1676 Mulkey Road Austell, Georgia 30001
Durrett, Donald M. Fulton—Active—R	1170 Cleveland Ave. East Point, Georgia 30344
Hatfield, Hugh A. DeKalb—Active—GP	5368 Peachtree Road Chamblee, Georgia 30341
Henderson, Warren S. P. Baldwin—Active—Su	Central State Hospital Milledgeville, Georgia 31061
Houser, Frank M., Jr. Whitfield—Active—Pd	Memorial Drive Dalton, Georgia 30720
Hulsey, Wayne G. Muscogee—Associate	Medical Center Columbus, Georgia 31906
Konigsberg, Charles, Jr. Bibb—Active—Ph	770 Hemlock St. Macon, Georgia 31201
Labiche, Henry M., Jr. Ware—Active—Path	410 Darling Ave. Waycross, Georgia 31501
Lobel, A. Beata DeKalb—Active—Pd	1275 McConnell Dr. Decatur, Georgia 30033
Luckett, James M. DeKalb—Active—R	2701 N. Decatur Rd. Decatur, Georgia 30030
Meyer, Carol F. Richmond—Active—Pd	Medical College of Georgia Augusta, Georgia 30902
Rodriguez, Humberto S. Ga.—Active—Su	901 N. Parrish Ave. Adel, Georgia 31620
Sapp, Philip B. Whitfield—Active—Er	Hamilton Memorial Hos- pital Dalton, Georgia 30720
Strom, Carl H. DeKalb—Active—PM	3300 Memorial Drive Decatur, Georgia 30032
Wallace, Douglas W. Muscogee—Associate	Medical Center Columbus, Georgia 31906
Weiss, Edward A. Glynn—Active—N	2601 Parkwood Drive Brunswick, Georgia 31520

SOCIETIES

The **Floyd County Medical Society** plans to ask the county commission to increase its funding of indigent patient care and to underwrite a program to attract new doctors to the Rome area.

The **Medical Association of Atlanta** heard a report on operation of a mobile coronary care unit in Columbus, Ohio at their April meeting. Dr. Richard Lewis, acting director of Ohio State University's division of cardiology was guest speaker.

PERSONALS

First District

Ilhan M. Ermutlu of Savannah presented information about the Georgia Regional Hospital in Savannah and how it serves Glynn County to a meeting of the Glynn County Association for Mental Health in April.

Arnold P. Mulkey of Millen was named Rotary "Man of the Year" for that city at a banquet sponsored by the Millen Rotary Club in April.

John Brewton Rabun was named a fellow of the American College of Radiology at that organization's 49th annual meeting in April. Dr. Rabun is from Savannah.

Second District

Vance Watt of Thomasville has been named chief of medical staff at Archbold Memorial Hospital, succeeding Dr. Huddie L. Cheney.

Third District

W. McCall Calhoun, of Buena Vista, has been named to *Who's Who in America*, 1972 publication.

Dan Callahan of Warner Robins was awarded the U. S. Air Force's Exceptional Service Award in April.

C. Daniel Cabaniss of Columbus has been named assistant dean for medical administration at the Columbus Medical Center by Dr. Arthur P. Richardson, dean of the Emory University School of Medicine.

Fifth District

Pangiotis N. Symbas of Atlanta was noted in an April article in the *Atlanta Journal* for his development of the autotransfusion procedure.

Harold S. Ramos of Atlanta has been named assistant dean at Crawford W. Long Hospital by Dr. Arthur P. Richardson, dean of the Emory University School of Medicine.

Tenth District

William H. Moretz has been elected the new president of the Medical College of Georgia by the Regents of the University System.

DEATHS

Oscar Rance Styles, Sr.

Oscar Rance Styles, Sr., died April 24 in Emory Hospital after a short illness. He was 83.

Dr. Styles, a resident of Cedartown since 1941, was a member of the First Baptist Church, a Mason, member of the Yaarab Temple and a director of the Carrollton Federal Savings & Loan Association.

Graduating from Emory University School of Medicine in 1915, he opened his first office in Bowdon, before moving to Cedartown in 1941.

Dr. Styles is survived by his widow, the former Hattie Mae Sims of Cedartown; one daughter, Mrs. J. V. Ham of Cedartown; one son, O. R. Styles, Jr., of Cedartown; four grandchildren and five great-grandchildren.

THE MONTH IN WASHINGTON

House-Senate differences and time pressures may well stall congressional action this year on the three major health measures before the lawmakers . . . national health insurance, health maintenance organizations (HMO's), and the Social Security Amendments to medicare and medicaid.

The death knell for national health insurance in this Congress may have been rung by House Ways and Means Committee chairman Wilbur Mills (D-Ark.), who now says he doubts if he will hold even executive sessions on the controversial measure.

The medicare-medicare amendments (H.R.1) which contain the professional standards review organization plan (PSRO), medicare for the disabled, and other amendments to the Social Security law, seem to face a rocky, uphill road in the Senate. One of the many controversial measures in the bill is Senator Long's (D-La.) catastrophic protection measure. To date Chairman Long has failed to sell the catastrophic proposal to a majority of his fellow members of the Senate Finance Committee. To make Long's road even tougher to travel are grumblings from Mills over in the House that he won't buy the catastrophic proposal, nor PSRO as presently written. But Long is a wiley maneuverer and the chances that the Senate can come up with a version of H.R.1 satisfactory to the House are still not completely dead.

HMO Proposals

Not yet quite counted out this year are the HMO proposals in both the Senate and House. Senator Edward Kennedy (D-Mass.) insists he's going to push hard and swiftly for his sweeping HMO plan, but Administration and House health lawmakers view Kennedy's plan as too expensive, too rigid. Settling these differences and working out a satisfactory compromise in limited time remaining for Congress might be tough.

The Administration says the Kennedy HMO bill could cost individuals \$600 a year, a family of four, \$2,400. The Kennedy plan was also criticized for the scope of benefits proposed and for too rigid requirements on what makes up an HMO by HEW Secretary Elliot Richardson.

Testifying before Kennedy's health subcommittee, Richardson compared the individual cost of \$240 a

year estimated in the Administration bill with the \$600 estimate for Kennedy's plan. The senator challenged the figure, suggesting that it would be closer to \$400.

Tight Restrictions

Richardson said "tight restrictions" in the senator's measure "would exclude individual practice HMO's, or medical foundation plans in urban areas from federal support and this would create a severe disincentive to their formation."

The HEW Secretary also took issue with Kennedy's plan for an HMO trust fund to cover the costs of premiums for people who can't afford them. Provisions for federal financing of health services should not be included in a health delivery systems bill but in a national health insurance proposal, Richardson said. "Moreover, the earmarking of particular federal tax receipts for specific purposes is inconsistent with the basic principles of good budget management."

Kennedy's bill would go beyond the Administration bill by requiring that HMO's provide mental health and dental care among other benefits.

"The approach in your bill is over-elaborate," Richardson said. "The more comprehensive the benefit package, the fewer the organizations will qualify," he said. "That is why the Administration bill has taken a quite general benefit approach."

Urges Caution

The American Medical Association has urged Congress to observe a "flashing yellow light of caution" before rushing into large-scale HMO programs.

Testifying before the House Subcommittee on Health and Environment were John R. Kernodle, M.D., Burlington, N. C., vice chairman of the AMA Board of Trustees, and Russell B. Roth, M.D., Erie, Pa., speaker of the Association's House of Delegates.

Dr. Kernodle said that "considerable funds have already been allocated for HMO's. We urgently need to evaluate these initial efforts."

The North Carolina group practitioner told the subcommittee that the AMA favors a pluralistic system of medical care.

"We believe different methods of medical care should be allowed to compete freely in the marketplace to satisfy varying public demands," he said.

Satisfactory Method

"We strongly believe that no one method of medical care can satisfy all. No one method of care should be imposed and no one method should be so heavily subsidized or otherwise encouraged as to undermine the working of free choice.

"Believing in a pluralistic approach we feel that HMO's merit trial. But the basis should be limited, experimental. The possible benefits to health in terms of service rendered and their possible efficiencies in terms of cost reduction should then be objectively measured against the possible shortcomings and deficiencies."

Dr. Kernodle noted that the Administration has made 110 planning and development grants, and is requesting \$27 million in a supplemental budget for this year and \$60 million next year to speed these programs.

"Conceivably," he said, "the HMO could solve some of our problems. But that is not yet proven.

"HMO's could represent a giant step backwards to a type of contract medicine the public rejected half a century ago."

Record of Failure

Dr. Kernodle said that even in recent years contract medicine has had a "sobering record of failure—the passing of the Rip Van Winkle group in Hudson, N. Y., declining enrollments in the Community Health Association of Detroit and the Inter-County Hospital Plan of Johnston, Pa.—all these signals flash a bright yellow caution light."

The AMA official questioned "the ability of the HMO to fulfill the public hope for the kind of medical care they want at a low cost."

"We question too that the type of practice offered in an HMO will attract a substantial segment of the medical profession," he added.

"I hope I have suggested that there is much reason to proceed with caution. We should first gain experience with test models and see if they fly before we order a whole fleet.

"Considerable funds have already been allocated for HMO's. What is urgently needed now is a sound, objective mechanism with which to evaluate the initial efforts."

Cautious Expansion

In his testimony, Dr. Roth also urged the subcommittee members to be cautious in expanding HMO programs. He said:

"The federal government has already made some 110 grants for planning and for feasibility studies for HMO's. But the results of these studies and plans are as yet unknown in terms of the quality and extent of the services which can be provided, their accessibility to beneficiaries, the cost of providing them, and their acceptability to consumers and providers alike.

"We believe that the present range of federally funded experimentation is quite adequate to provide most of the desired answers in a few years. On the other hand, we believe that the announced goal of having HMO's available to 80 per cent of the population within a decade is indefensible overpromise."

Dr. Roth concluded, "We further propose a moratorium on the funding of additional planning for, or subsidy of, HMO operation until existing experimental programs can be evaluated in terms of quality of service, efficiency, availability, and economy."

X-Ray Warning

Mobile x-ray equipment should not be used for general-population surveys for tuberculosis and other chest diseases, says a statement by the American College of Chest Physicians, American College of Radiology, and the Food and Drug Administration.

The equipment used in many parts of the country "is not productive as a screening procedure for chest disease detection," the statement says.

The joint statement supercedes a 1958 policy declaration by the U. S. Surgeon General that said mass chest x-rays should be conducted "selectively" with groups "at high risk of tuberculosis infection."

The new policy was indicated "in large part by the fact that tuberculosis is now almost nonexistent in many regions of the country," said Merlin K. DuVal, M.D., HEW Undersecretary for Health and Scientific Affairs. "The use of mobile equipment, which requires relatively higher levels of x-ray exposure than fixed equipment, simply cannot be justified." Records of the number of mobile x-ray units still being used are not available. Twenty-eight states had registered one or more x-ray vans for use in 1970, but several of these have since discontinued use of the equipment. The 1970 information will be updated after July 1, this year, the FDA's Bureau of Radiological Health said.

The new policy recommends full size x-ray film when x-ray screening of selected population groups is essential. The recommendation is intended to discourage the use of photofluorographic equipment that uses a fluoroscope screen in combination with miniature photographic film.

Military M.D. Pay

In hopes of retaining and attracting sufficient numbers of physicians in the armed forces without resorting to a continuation of the physician draft, the Administration offered Congress a special pay program under which military physicians could earn above \$40,000 a year.

Under the plan, the military services are authorized to give physicians as much as \$17,000 a year in extra pay. This would be on top of \$350 a month above the base pay for their rank after two years of service.

The bill also continues the special pay provision now in effect, but that would expire when the draft ends, of \$100 a month additional for the first two years of service. At present, the \$100 a month is increased to \$350 a month in steps after two years of service. However, the bill speeds the process up by inaugurating the \$350 monthly special pay immediately after two years. The \$17,000 continuation pay is a maximum and most physicians would not receive this much. Thus after two years, a military physician could earn at most the salary of his rank, plus \$350 a month, plus \$17,000 a year.

The bill also provides that public health service commissioned corps officers could receive up to four months additional pay per year over their military rank salary for signing up.

Abuse Contribution

Federal researchers reported that findings from recent national surveys challenge the view that the prescribing habits of American physicians may contribute to the rising incidence of drug abuse.

Drs. Mitchell Balter, Ph.D., and Jerome Levine, M.D. of the National Institutes of Mental Health say:

"Our data indicate that most private practitioners, if anything, err in the conservative direction," in prescribing psychotherapeutic drugs. They see little likelihood that doctors contribute to drug abuse by creating physical dependence among their patients.

Less than half of those surveyed who showed "high levels of psychic distress" had used any psychotherapeutic medication obtained on prescriptions during the past year.

In the study, 43 per cent of the males and 54 per cent of the females who had used prescription psycho-

therapeutic drugs during the past year had a high level of psychic distress, indicating treatment had been necessary.

Other general findings include:

- No evidence for claims that Americans are chronic users of psychotherapeutic drugs.

- Americans are conservative in their attitudes toward using tranquilizers. Most agree that doctors prescribe such drugs more than they should, and held it is better to use willpower to solve problems, which tranquilizers may cover up.

- Despite national differences, the rate of prescriptions filled in the U. S. is similar to rates found in several European countries. That is slightly more than five prescriptions per person per year.

The conclusions were drawn from NIMH sponsored studies designed to gather data on prescriptions filled in U. S. drugstores, on the prescribing behavior of private physicians, and on pattern of drug acquisition and usage among adults.

SYMPOSIUM '72 A SUCCESS

The recent Cobb County Symposium '72 "The Search for Relevance in The Seventies," the 7th annual Symposium co-sponsored by the Cobb County Medical Society through the Committee on Medicine and Religion, was extremely successful and attracted physicians from as far away as South Dakota; Winston-Salem, North Carolina; and Richmond, Virginia. The program was video-taped by WGTV-channel 8, Athens, Georgia, and later on highlights of the conference will be presented in a 30-minute color television program on channel 8. Newspaper announcements will be made later about the showing.

It might be of interest to note that the dates for Symposium '73 will be April 26-27, 1973, and will be entitled "The Creation of Man." Featured on this program will be Dr. Paul Ramsey, Professor of Religion at Princeton. He was for two semesters Joseph P. Kennedy, Jr. Foundation Visiting Professor of genetic ethics at Georgetown University Medical School. Also, he has written many books including "Fabricated Man—The Ethics of Genetic Control" and "The Patient as Person." Rabbi Alvin J. Reines, who holds a Ph.D. from Harvard University, will also be featured on the program for '73. He is Professor of Jewish Philosophy at the Hebrew Union College-Jewish Institute of Religion, Cincinnati, Ohio.

Anyone who would like to be on the mailing list for Symposium in the future should write to Cobb County Symposium, Kennesaw Junior College, Marietta, Georgia 30060.

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THE MEDICAL ASSOCIATION OF GEORGIA has received a grant from the National Center for Health Services, Research and Development. The funded project is called Experimental Medical Care Review Organization. The Medical Association of Georgia is accepting applications for the position of project director. Applicants must be physician licensed to practice in Georgia. Interested parties should submit a curriculum vitae to Mr. A. R. Jablonowski, Associate Director, Medical Association of Georgia, 938 Peachtree St., Atlanta, Ga. 30309.

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